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NHS

Lambeth Primary Care Trust

2012-13 Annual Report and Accounts

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Lambeth Primary Care Trust

2012-13 Annual Report

NHS Lambeth

Annual Report 2012/13

LAMBETH PRIMARY CARE TRUST

ANNUAL REPORT

FINANCIAL STATEMENTS & ACCOUNTS

.

A partnership of Primary Care Trusts in Bromley, Greenwich, Lambeth, Lewisham, Southwark and Bexley Care Trust

Chair: Caroline Hewitt Chief Executive: Andrew Kenworthy CCG Chair: Adrian McLachlan

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WELCOME

We are pleased to welcome you to the 2012/13 Lambeth PCT Annual Report.

This is the final annual report to be published by Lambeth PCT, which along with every PCT in England ceased to exist on 31 March 2013. As a result of the reforms set out in the Health and Social Care Act 2012 from 1 April 2013 commissioning for health services and health improvement in Lambeth became the responsibility of NHS Lambeth Clinical Commissioning Group (CCG), the NHS Commissioning Board and Lambeth Council.

We are pleased to be able to report that, working with colleagues from across the NHS and local government we have secured a safe and successful transfer of PCT responsibilities to new organisations, and from January 2013, the full and unconditional authorisation of NHS Lambeth CCG by the NHS Commissioning Board.

Throughout the last two years of transition we have also continued to focus on our priority health goals. Working with local people and with partners across Lambeth and South East London we have achieved further improvement in the health of Lambeth's communities and in the quality of local health services available to them.

This Annual Report sets out the work we have done to address the major health issues facing the people of Lambeth and our achievements over the past year, including the additional planning that was needed to successfully support the Diamond Jubilee celebrations and the 2012 London Olympic and Paralympic Games. As in previous years we have worked hard with our partners to develop innovative and quality services for local people that seek to meet the increasing health needs of a growing and ageing population, within a constrained resource environment. Our focus has remained on supporting individuals to stay healthier for longer, on early detection and prevention of ill health and better coordinated and integrated services for those people who need additional support and specialist care.

Health and service quality improvement in Lambeth is underpinned by our collaboration with all of our partners, including local people and local clinicians as we have sought to ensure high quality services that are more accessible and more responsive to the specific needs of individuals and of communities of Lambeth. Our work with primary care clinicians through the Lambeth Clinical Commissioning Collaborative, has supported a greater focus on clinical quality as well as wider and more successful engagement with colleagues from across all parts of the NHS. We equally recognise the critical importance of local patients and of our communities active involvement in shaping, designing and telling us about their local services. Our clear ambition for 2012-13 has been to build upon our innovative approaches of collaborative working, recognising there will be much more we can do in this regard.

Lambeth PCT has met the challenge and had a successful year. Amongst the many successes in 2012-13 we are particularly proud that:

- We opened the Akerman Road Health Centre in North Brixton bringing two GP practices, community health services and a range of services normally provided in hospitals to an area of the borough with marked health needs
- Lambeth Children's Safeguarding and Looked After Services were rated as "outstanding" in overall effectiveness and capacity for improvement by the joint Ofsted/Care Quality Commission Review.
- We launched the Southwark and Lambeth Integrated Care programme (SLICare) for frail elderly patients, one of the first major schemes of its kind in the UK, including a multi-million pound investment in preventative community services better supporting people in their own homes and supporting recovery following hospital care.
- We now have 44 pharmacies accredited as Healthy Living Pharmacies. These pharmacies provide a Stop Smoking service, Alcohol Screening, Emergency Hormone Contraception and NHS Vascular Healthchecks. Each pharmacy also has at least one fully trained Healthy Living Champion who can signpost patients to health promotion advice and support. NHS Lambeth was the first PCT in London to participate in this innovative scheme.
- We launched new services for people with long term health conditions including three new community diabetes teams and a new minor eye conditions scheme supporting patients to see an optometrist closer to home for advice and treatment.

Over the ten years since it was established, the PCT has consistently earned a reputation for effective financial stewardship and securing value for money. In its final year the PCT once again achieved all of its statutory financial duties, delivered upon its target 1% surplus and reinvested available resources to secure service improvement.

We want to thank Lambeth PCT staff for their commitment and hard work on behalf of Lambeth people throughout this period of extended change. We wish all of our staff well in the future as they seek to build upon the successful legacy of the PCT and to realise the additional opportunities for improvement that clinically-led commissioning and public health working within Local Government will offer.

Our achievements and successes are also testimony to the value we place on our effective local partnerships and the commitment of all of our partners to improve the health of local people and the quality of health services available to them. We would wish to thank them for their support over many years in delivering our shared ambitions for better health in Lambeth.

Lastly, we would want offer our best wishes to NHS Lambeth Clinical Commissioning Group as it takes forward the challenge of improving healthcare for the people of Lambeth. On the basis of the CCGs development over the past two years, recognised in

its successful authorisation we believe that Lambeth communities can have confidence that clinical commissioning can continue to support improvement even as the challenge clinical commissioners will face in addressing the growing demand for services within limited resources become more pressing

Caroline Hewitt , Chair, NHS South East London (including Lambeth PCT)

Andrew Kenworthy, Chief Executive, NHS South East London (including Lambeth PCT)

Dr Adrian McLachlan Chair of Lambeth Clinical Commissioning Group

1. WHAT WE DO

Lambeth PCT is responsible for improving health and wellbeing for the people who live, work or visit Lambeth. We assess local healthcare needs and then arrange and pay for the healthcare services needed to meet those needs (we call this 'commissioning'). During 2012/13 the Lambeth PCT Board has been supported by the Lambeth Clinical Commissioning Group (formerly know as the Lambeth Clinical Commissioning Collaborative), local primary care clinicians who are taking on the work of commissioning to improve the health of Lambeth people and to enhance the quality of local health services.

Working with our partners in the local NHS (GPs, pharmacists, dentists, opticians, hospital and mental health providers), with other borough partners (including Lambeth Council and local voluntary and community groups) and with local people and patients, we seek to improve health and wellbeing and reduce health inequalities, ensuring everyone has equal access to the highest quality healthcare services.

Together we offer the people of Lambeth a wide range of services to help them stay healthy and to care for them when they fall ill and need extra support. We aim to deliver high quality services that give our communities the right care, at the right time, in the right place and that are easy for people to use.

In 2012/3 we had a total spend of over £674 million to commission health services, using funds we received from the Department of Health. This report sets out how we spent this money on behalf of Lambeth's communities.

The vast majority of people using the NHS in Lambeth will use primary and community health services. We commission these services from:

- GPs, pharmacists, opticians and dentists.

- Community health services such as district and school nursing, health visiting, specialist child health, therapy services and care for older people, provided through Guy's and St Thomas' Foundation Trust.
- Voluntary and third sector care providers.

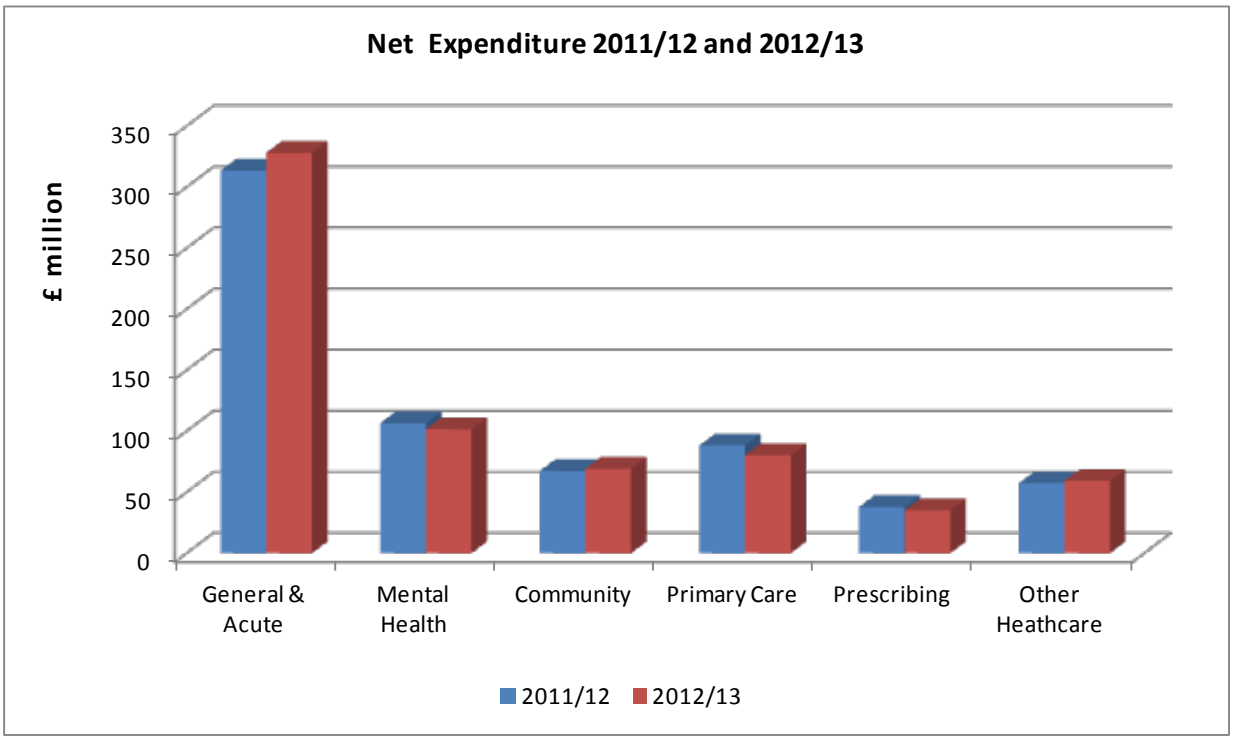
When people require more specialist care, we also commission:

- Guy's and St Thomas' NHS Foundation Trust, Kings Healthcare NHS Foundation Trust and St George's NHS Trust to provide inpatient, outpatient, day and emergency care.
- South London and Maudsley NHS Foundation Trust to provide mental health and addictions services

1.1 How we spent your money

During 2012/13 we spent:

- **£558m on secondary and community healthcare** of which mental health £102m; general & acute £324m, accident & emergency £15m, maternity £24m, community £69m, learning difficulties and other contractual £24m.
- **£115m on primary healthcare** of which, primary medical services £57m; prescribing £35m; dental services £14m; new pharmacy contract £7m and ophthalmic contracts £2m.



1.2 Health of Lambeth People

Lambeth is an ethnically diverse inner London borough with high levels of deprivation, inequalities and unemployment. It is the 9th most deprived borough in London and the 29th in England.[1] There are over 303,000 people living in Lambeth, a figure projected to grow to 347,000 by 2031 with 23.79 percent identified as coming from black minority ethnic backgrounds, the primary ethnic identifiers being Black Caribbean, Black African or Black Other.[2] Over 383,000 people are registered with Lambeth GP practices.

Lambeth has a young and mobile population with estimates that as many as 20 percent of people move in and out of the borough each year. These factors place a greater demand on health provision and make delivering services such as screening and immunisation programmes challenging.

Compared to the 2012 average data for England as a whole, Life expectancy, whilst improving locally, is significantly worse than the average and premature mortality is higher than the average due to a larger number of people with health conditions including circulatory diseases, cancers, and respiratory conditions. There are other high levels of health needs in Lambeth such as long-term conditions (diabetes, cancer, coronary heart disease, HIV and respiratory diseases), mental health, sexual health, substance misuse and childhood obesity.[3]

We have a good understanding of the health needs of Lambeth communities and of the inequalities in health that exist. We know that whilst Lambeth people are generally living longer, many are living for significant periods of their lives with long term health conditions, often undetected for some time. You can find out more information about the health of the Lambeth population at http://www.lambeth.gov.uk/Services/CouncilDemocracy/JSNA.htm

1.3 Our Mission, our Vision and our Health Goals

Our **Mission** - improving health and reducing health inequalities of Lambeth people and commissioning the highest quality health services on their behalf.

Our **Vision** - focusing on four core commitments:

[1] Office of National Statistics - www.ons.gov.uk/ons/rel/hsq/health-statistics-quarterly/no--53--spring-2012/uk-indices-of-multiple-deprivation.html
[2] UK Census 2011
[3] Lambeth Health Profile 2012 – Association of Public Health Observatories

Health: Health improvement has been the core of our business, with the aim of increasing life expectancy for all and reducing the difference in life expectancy between the most and least deprived in our diverse communities.

Affordability: Maintaining a thriving, financially viable, health economy delivering safe and effective high quality care.

Access: Commissioning comprehensive integrated care that meets the needs of local people; valuing the diverse range of providers, whilst expecting excellent outcomes.

Cutting Edge: Delivery of our vision has required:

- A rigorous population needs based approach to commissioning, supported by public health expertise.
- Collaborative working with Lambeth people and their representatives to commission services that best meet their needs.
- Working in partnership with colleagues, across geographic, organisational and professional boundaries. This includes general practices and other primary care providers, the London Borough of Lambeth, King's Health Partners as well as neighbouring health commissioners.
- Support for innovation in workforce development and in the local application of teaching, training and research.
- Looking first to local colleagues for management support.

In order to achieve our Mission we put in place in 2009/10 our 5 Year Strategic Plan which established six core priority Health Goals which will have the greatest impact on the health of Lambeth people over present and subsequent years. This Strategy is being continued under the leadership of the NHS Lambeth Clinical Commissioning Group, which has added a 7th Health Goal dealing with Alcohol.

Our Health Goals:

Serious mental illness
Enable 1000 people with people with serious mental illness to move on from secondary care by accessing a new asset and recovery based service offer.

Smoking
Help over 12,500 more people in Lambeth quit smoking.

Cardio Vascular Disease
Improve hypertension control of 1,000 more people in Lambeth

Diabetes
Help 5,000 more people with diabetes bring their blood sugar under control

HIV Prevention
Halve the proportion of Lambeth residents diagnosed very late with HIV (<200 CD4 cells/mm3)

Childhood obesity
Help 900 more children overcome or avoid obesity; and help over 10,000 children maintain a healthy weight

Alcohol
Reduce the health impact of alcohol by increasing the number of frontline staff who can deliver screening and brief intervention

1.4 Equality Delivery System

In 2011, we adopted the Equality Delivery System (EDS) which aims to achieve positive cultural change in the NHS by creating an environment where services for patients and workplaces for staff are more equitable, diverse and that fairly represent the wider community.

The EDS enables us to meet the aims of the Equality Act 2010 and to take the necessary actions to achieve:

- Elimination of unlawful discrimination.
- Advancement of equality of opportunity.
- Fostering of good relations between individuals and communities.

Our achievements have included:

- Launch of our EDS with local partners.
- Agreed equality objectives which are embedded in local contracts with NHS providers.
- Ensuring all local NHS organisations comply with the Public Sector Equality Duty

As part of our future planning we are establishing equalities outcome indicators to support the reduction of health inequalities in each of our priority health goals.

Our future challenges and opportunities include:

- Ensuring employers and staff in the NHS embrace the needs of a diverse population.
- Embedding equality into the new future organisations.

- Recognising that delivering our equality objectives and improved experiences for disadvantaged groups are critical to reducing health inequalities and improving health outcomes for all.
- Ensuring that our Joint Strategic Needs Assessment covers all the protected characteristics and key disadvantaged groups.

For more information on our Lambeth PCT EDS visit http://www.webarchive.org.uk/wayback/archive/20130329030120/http://www.selondon.nhs.uk/your_local_nhs/lambeth/publications

2. HEALTH AND WELLBEING IN LAMBETH

We are proud of the achievements in improving health and reducing health inequalities over the previous year.

2.1 Reducing Health Inequalities:

Lambeth residents live longer than 10 years ago (men 77 years and women 81 years). The life expectancy gap over the same period has narrowed between Lambeth and England as a whole. However life expectancy is still shorter in Lambeth when compared to England.

In 2008 life expectancy for men living in the least deprived area in Lambeth was 5 years higher than for those living in the most deprived area. For women the difference was 4 years. In considering healthy life expectancy people living in the least deprived areas live 6 years longer without disability compared to those living in the most deprived areas of Lambeth.

Infant mortality rates have declined from 8.8 per 100 live births in 1995-07 to 5.4 per 1000 live births in 2007-09 (just above that of England - 4.7). It has increased to 6.2 per 1000 live births in 2008-10 (compared to England 4.6 per 1000 live births). The difference between Lambeth and England is not statistically significant[4]

With regard to the the risk of infant deaths the socio-economic gap remains more pronounced in Lambeth than in England nationally. Some local risk factors for infant death, such as teenage pregnancy, have decreased. The teenage conception rate has declined but still remains higher than average with over 50 conceptions per 1,000 girls aged 15-17 years. Since 1998 there has been a reduction of 39 per 1000 live births. A review of modifiable factors identified systemic issues such as late antenatal presentation.

[4] http://www.lho.org.uk/NHII/InfantMortality/data/IMdl1_Trends09.xls#'R&M imrs and CIs'!A1

Reasons for late presentation range from lack of understanding of the health system to issues of non-comprehension and misunderstanding resulting from language barriers.

Deaths that occur below 75 years of age are considered “premature deaths” where a significant proportion of these deaths could have been prevented by avoiding risk factors, and improving early detection and/or effective health care management. The main causes of the excess premature deaths in Lambeth are cancer, cardiovascular disease (heart disease and strokes) respiratory disease and diseases of digestive system. The risk of premature death by each of these causes has reduced in Lambeth. The three year average premature mortality from circulatory diseases has fallen by 50% in 10 years and the average premature mortality from all cancers has fallen by 15% in 10 years.
It should be noted that here is some evidence of variability between general practices in detection and control of long term conditions even after making adjustments for differences in population characteristics. For example, detection of diabetes varies between practices, after adjusting for expected prevalence: from 28% to 83% detected to expected diabetes cases by March 2011. Practice based data also shows that people with Severe Mental Illness (SMI) are twice as likely to smoke (44% cf 22%) than the general GP registered population; are much more likely to be overweight or obese (55% cf. 35%). A quarter of people with SMI have an additional long term condition.

More generally, progress on reducing health inequalities in Lambeth is supported by a range of factors:

- Our commissioning strategy priorities which focus on the main causes of excess premature deaths; the main causes of long term ill health; the main risk factors for these conditions, and on working with our partners to mitigate the effects of the economic downturn and the welfare benefit reforms on health and health inequalities. Actions include co-developing monitoring indicators with Lambeth Council, facilitating signposting from general practices for patients being reassessed for their welfare benefit
- A Lambeth Health and well being strategy has been developed using an evidence based health inequality framework
- Public health has begun planning work involving health inequality, equality and wellbeing impact assessment into the planning process.
- NHS providers have been working together to ensure equitable access and outcomes from health services. During 2012/13 equity audits were conducted for diabetes management, hypertension management and cholesterol control. Some of the findings informed GP education and commissioning targets. The assessment of social care needs when delivering HIV care, services for older people and mental health.
- The analysis and review of information informing the Joint Strategic Needs Assessment
- Support for NHS Lambeth to undertake equality impact assessment as a regular part of the commissioning process

- The development of equality access objectives to support NHS Lambeth to make faster progress towards achieving its priorities
- A wellbeing programme to encourage partners and the community to invest and participate in a number of initiatives promoting resilience and mental wellbeing in the population as well as helping to tackle stigma, discrimination and its overall impact on health

In conjunction with the local authorities and other stakeholders, the PCT has been developing a food strategy. The aim is to promote a local food system which is healthy, improves wellbeing, is affordable, fair, encourages local employment and develops skills. Our discussions with a variety of stakeholders have helped identify a number of themes which we will be exploring further: education, networking, policy, food poverty, access, waste, cultural behaviour, environmental sustainability, procurement and the local economy.

2.2 Improving Health through our priority Health Goals.

We have a strategy in place to deliver improved health through the delivery of improved outcomes in seven core priority health goals

Priority Health Goal 1: Serious Mental Illness

Serious Mental Illness is being progressed by the Lambeth Living Well Collaborative via the Transforming Primary and Community Mental Health Services programme. This is one of the five programmes under the Mental Health Improvement Programme (MHIP). See section 2.3.3 for more information about the MHIP.

High levels of inequality and deprivation mean there are higher than average levels of mental ill health in Lambeth. At any one time, approximately 4,000 people with severe mental illness are registered with GPs in Lambeth – nearly three times the average expected from national surveys. Just over half of these are clients of South London and the Maudsley NHS Foundation Trust (SLAM).

People with mental ill health are more likely to experience poor physical health. Twelve per cent of people with severe mental illness in Lambeth are known to have diabetes compared with four per cent of the general population. People with mental ill health are more likely to smoke, eat poorly and exercise less than the population average and have a shorter life expectancy. In light of this the CCG (April 2012) has agreed the following key equality objectives

1. To increase access to the memory service for people from ethnic minority communities
2. To improve the physical health of people known to have mental health problems especially people with severe mental illness (SMI)

3. To increase access to talking therapy services to those people over 55 and who have long term conditions

SLaM provides mental health services to over 8,000 Lambeth residents and GPs have recorded around 22,000 people with depression. Nationally, about 15 per cent of the adult population is thought to be experiencing some form of common mental health disorder (e.g. anxiety, depression, phobias, and obsessive compulsive disorders) at any one time. In Lambeth, this equates to between 30,000-53,000 people aged 16-74 years. However, only about half of these people will seek help. The number of women with common mental health disorders is substantially higher (19.7 per cent) than in men (12.5 per cent). Lambeth also has a high number of people within the secure mental health system (low, medium and high secure settings).

We aim to deliver a whole system redesign for people who experience serious mental illness, focusing on recovery, early intervention and prevention. To achieve this partners from across the borough have come together to form the Lambeth Living Well Collaborative comprised of users, carers, GPs and wider primary care, voluntary sector, secondary care (South London and Maudsley NHS Foundation Trust) and Lambeth Council.

The Living Well Collaborative has undertaken extensive engagement with users, carers and partners, 1600 people. This has resulted in broad agreement on a much improved service offer which it is currently being implemented. This includes building capacity within primary care via the new primary care mental health support service (PASS); recovery focused provision within the Voluntary sector via the Community Options service; a more responsive and easier to navigate secondary care (SLaM); extensive development of peer support networks and the expansion of time banking across the borough.

Progress achieved during 2012/13 includes:

- 200 people supported by our Community Options Team
- 60 people currently being supported Primary Care Support Service
- Ling Well Partnership Information Hub opens February 2013
- One Recovery and support Plan agreed for whole system
- 3 locality based Time banking partnerships growing
- 10 Peer Support initiatives in place
- So far 35 people had Personal Health Budget to support recovery and many more in the pipeline!
- Range of culture change initiatives including peer support, support planning, co design work
- Growing bank of evidence that co-production works in terms of improved outcomes and reduced cost (move on from residential care, community Options Service, Personal Health Budgets)

Priority Health Goal 2: Smoking

Smoking is the biggest cause of premature death in the borough, and action to bring down smoking rates will improve local health and wellbeing and help reduce health inequalities. We estimate that around 270 residents may be dying due to smoking related conditions every year. Smoking rates are slightly higher in Lambeth (21 per cent) than in London as a whole (19 per cent). Smoking rates are relatively higher in more deprived areas of Lambeth. The DH have set NHS Lambeth a target of 2232 smokers quitting for 2012/13 and we are on target to achieve this through the support of our Lambeth stop smoking service.

- We continue to work with our partners across the borough through the Lambeth Tobacco Control Alliance to implement our tobacco control strategy, preventing the uptake of smoking and giving individual smokers support to help them kick the habit.
- Our GP practices and pharmacists promote and provide stop smoking services
- Smoking cessation events are held in shopping areas, Lambeth College and at tube stations.
- We run a number of stop smoking groups that meet in a variety of locations and we have run specialist groups for those affected by mental health and we have worked with a crèche facility to help new mums.
- We contact people who didn't manage to quit first time to get them to try again.

Priority Health Goal 3: CVD (Cardio-vascular Disease)

Lambeth has a high rate of life lost due to mortality from circulatory diseases (heart disease and stroke) and these remain an important burden despite large reductions in mortality in the last decade. They contribute to the life expectancy gap between Lambeth and England as a whole and Lambeth has a higher premature mortality from circulatory diseases compared to nationally. Important preventable risk factors include smoking, raised blood pressure and raised cholesterol levels. Variations in detection and management are also contributory factors.

During 2012/13 we have focused on developing education to primary care, optimising patient outcomes and developing services for prevention, early detection and intervention. During 2012/13 we have:

- Initiated a new service to support improved management of atrial fibrillation, hypertension and lipid management, through delivery of patient clinics and education to primary care.
- We have continued to deliver successful education sessions in collaboration with KHP around the diagnosis and management of heart failure and atrial fibrillation.
- Reviewed the community heart failure service and developed a more robust education element and a programme of visits
- Optimised heart failure medications through virtual clinics with a number of practices through the Medicines Optimisation Scheme
- The NHS Vascular Health Checks programme has been rolled out to a number of community pharmacies and Lambeth PCT are on track to exceed DH targets during 2012/13. We have continued to arrange training for frontline staff to ensure a core competency in health promotion, prevention and early detection/intervention. A key focus is the reduction and management of vascular related risk, which includes delivering strategies for smoking, diet, exercise, obesity, alcohol use plus mental health and wellbeing.
- Worked with the South London Cardiac and Stroke Network to manage the entry of new cardiac drugs across primary and secondary care.
- Developed and embedded the Lambeth Early Intervention and Prevention Service.
- Implemented the new NICE pathway for hypertension diagnosis including piloting two models of care for the delivery of ambulatory blood pressure measurement which will be evaluated in 2013/14 to inform future commissioning
- Undertaken a practice level audit to identify reasons for failing to achieve QOF targets for hypertension and cholesterol targets

Lambeth is making an important contribution to national reduction in gap for this indicator. Three-year average mortality rates for circulatory diseases (ages under 75) for Lambeth have fallen for each period since the baseline, from 175.3 deaths per 100,000 population in 1995-97 to 87.3 deaths per 100,000 population in 2008-10, a 50% improvement from the baseline rate. The absolute gap in mortality rates between England and Lambeth has reduced from a baseline gap of 34 deaths per 100,000 population in 1995-97 to 21 deaths per 100,000 population in 2008-10. The gap has therefore reduced by 40% percent since the baseline.

Priority Health Goal 4: Diabetes

Diabetes is a serious lifelong condition that can lead to multiple complications and premature deaths. Diabetes prevalence has been increasing locally and nationally. Locally detected cases have increased from about 10,000 in 2006 to over 13000 currently. It can affect people of all ages in every population. Socially disadvantaged groups in affluent societies and people from black and minority ethnic communities (especially those of South Asian, African and African-Caribbean descent) are particularly vulnerable.

Diabetes can have a major impact on the physical, psychological and material well-being of individuals and their families, and can lead to complications such as heart disease, stroke, renal failure, amputation and blindness.

We continue to deliver high quality and responsive services to support people with long-term conditions, helping them to manage these conditions more effectively. At the same time, improved detection and health promotion programmes mean that the number of people who are diagnosed as having a long-term condition is increasing.

Lambeth has one of the highest rates of hospital admission in London for patients with diabetes and over half of the people with diabetes in Lambeth have been seen in hospital for routine care.

We are in the third year of the Diabetes Modernisation Initiative supported by the Guy's and St Thomas' Charity. This brings together all aspects of diabetes care and treatment with patients, GPs, hospital clinicians, nurses, public health professionals and other care providers working together to produce a new model for identifying and treating diabetes, from identifying it earlier through to more effective programmes of treatment. The Diabetes Modernisation has recently developed a programme of self-management, which will be rolled out during 2013/14.

During 2012/13 we have worked on a major programme of work to improve patients' understanding of their condition, improve skills of GPs and Practice Nurses in support and routine care of people with diabetes and to deliver specialist services in a community setting. The Diabetes Modernisation has developed a self-management programme, which will be rolled out across the borough during 2013/14.

The unique Transfer of Care project, whereby appropriate patients are transferred from secondary to primary care for diabetes management has achieved a 24% reduction in inappropriate referrals to secondary care. The community clinics which support the Transfer of Care project are now provided in each locality within Lambeth and recent evaluation of the community service reveals a good standard of quality care and high patient satisfaction.

Priority Health Goal 5: HIV Prevention

In 2010, the Health Protection Agency reported[5] that there are 2,855 individuals resident in Lambeth living with HIV, with a further estimated 28 percent being unaware of their infection. Lambeth is by far the worst affected borough in the UK with a prevalence rate of 13.88 per 1,000. The average prevalence rate for HIV across London is 5.24 percent per 1,000. In the UK the HIV epidemic primarily affects two main patient groups, men having sex with men (MSM), black African heterosexuals. Lambeth has a 60/40 split of MSM and

[5] HPA (2010), Diagnosed HIV prevalence in Local Authorities in England, 2010

Black African heterosexuals living with diagnosed HIV. Late diagnosis of HIV (diagnosis with a CD4 count <350 will have had the infection for approximately 7 years) is the most important factor associated with HIV related morbidity and mortality and inpatient care in the UK. Late diagnosis of HIV infection contributes to 23 percent of new diagnosis in Lambeth. We have selected the reduction of late HIV diagnosis as our Staying Healthy target for HIV.

HIV testing is shifting from specialist services to integration with other health services. Testing is provided to specific high risk groups through specialised services (Sexual Health Services, drug service in partnership with GSTT community services, refugees and asylum seekers, prisons). HIV testing is also included in case of specific diagnosis such as tuberculosis and glandular fever. Antenatal HIV testing is universal.

Our five-year sexual health strategy has brought about major changes to the delivery of sexual health services in Lambeth. These include:

- Sexual health services are provided from a range of accessible settings that offer extended hours and a friendly and welcoming environment.
- Early HIV testing and diagnosis through 'test and link' strategies offer immediate access to life saving treatments and prevention of onward infection.
- Lambeth has led the way by setting up and developing HIV testing services in primary care. Data from January 2012 to September 2012 shows that 11 GP Practices carried out 2848 HIV tests with their newly registered adult patients. Access to HIV testing remains an issue. Fear of disclosure and criminalisation is the main barrier as well as low awareness of HIV and available care. An evaluation of HIV testing in primary care is underway which will inform a wider HIV testing strategy.
- Offer of HIV testing to patients at registration with a Lambeth GP is now part of the GP contract.
- Design and delivery of education and training programmes in order to both increase general HIV awareness in primary care and testing competency.
- 19 Lambeth GP and practice nurse clinicians have attended SHIP (Sexual Health in Practice) training in the last 4 months which offers an interactive, practical and peer led approach to changing primary care clinical practice around sexually transmitted infections and HIV testing.

A number of service reviews and needs assessments have been completed across the HIV care pathway over the last 2 years. An HIV prevention needs assessment took place in 2010/11 and identified early detection of HIV as a major priority in view of Lambeth HIV prevalence and the high levels of late diagnosis.

In 2012/13 the HIV Care & Support review has been taken forward. It originally included a comprehensive public health needs assessment and service review to ensure that HIV Care and support provision is modernised to reflect the changing needs of people living

with HIV in view of HIV epidemiology and treatment advances. This was a partnership project between health & social care. The service model proposals were subject to a 3 month public consultation which included extensive consultation events, focus groups with service users, an online survey function and opportunities for written responses. The original proposals were revised in light of the consultation responses and implementation of workstreams carried forward. Health Trainers were decommissioned and a plan put in place for 30% of people living with HIV who access specialist mental health services but could be seen in mainstream services to be appropriately re-directed from clinics and the existing service.

This project offers a strong example of engagement that has been guided by a robust engagement and consultation plan, ratified by both the project steering group, LSL Service user reference group and consulted on by local Health and Social Care Scrutiny panels. The Service User Reference group (SURG) has provided a shadow function to the project group and has reviewed and ratified all the stages of the project and proposals. The SURG continues to support proposal implementation over the next year or more and ensure that co-production with patients' remains central to this project.

These reviews will be used to inform the refresh of Lambeth's Sexual Health and HIV Strategy in partnership with Southwark and Lewisham during 2014/15. This strategy refresh will identify the future strategic objectives, commissioning intentions and service.

Priority Health Goal 5: Childhood Obesity

Childhood Obesity levels in Lambeth have been higher than the London and England averages. Overweight and obese children are likely to stay obese into adulthood and are at a greater risk of developing chronic conditions particularly diabetes and cardiovascular diseases at a young age. Childhood obesity is also associated with psychological problems such as low self-image and low self-confidence. Monitoring of childhood obesity in Lambeth is done through the annual national child measurement programme for Reception and Year 6 children.

A record 99.8% of Reception year and 100% of Year 6 children in Lambeth schools had their height and weight measured as part of the national child measurement programme. These participation rates were the highest in the country. Having such high participation allows for more children and their families to be engaged about healthy lifestyles and weight issues.

In Lambeth the data collected from the child measurement programme shows us that children aged 10 to 11 (Year 6) are at higher risk of being obese than the national average (24 percent compared to 19 percent nationally).
During 2011/12 we have introduced a range of initiatives to reduce childhood obesity:

- Confirmation of our UNICEF Baby Friendly Initiative (BFI) Certificate of Commitment for the implementation of the BFI to promote breastfeeding across all our children centres.
- Following on from our innovative approach to reduce childhood obesity through the development of the multi-agency healthy weight care pathway, more staff have been trained to ensure they are competent at health promotion, prevention and early detection of obesity in children.
- The Lambeth Ready Steady Go! Programme helps children who are above a healthy weight aged between 4 and 12 years old. This flexible programme supports the whole family and focuses on delivering long-term sustainable lifestyle changes. . There are three parts to the programme - MEND (Mind, Exercise, Nutrition, Do it!), RSG Saturday and RSG Holiday. Specialist services for children who require more support due to the complexity of their needs is also available.
- Healthy Weight training has been provided to over 200 health and non-health practitioners (including school staff) to help them understand the key issues impacting upon childhood obesity in Lambeth and to enable them raise the issue in a sensitive and appropriate manner.

Our initiatives are having an impact. The obesity level for Reception Year children is the lowest in Lambeth since the National Childhood Measurement Programme was introduced, although levels for both Reception and Year 6 are still higher than the London and England average. The obesity prevalence for Reception Year is 11.6% compared to 12.9% in 2009/10 and for Year 6 24% compared to 25.1% in 2009/10

Priority Health Goal 6: Alcohol

This was a new priority focus during 2012/13 based on the evidence across the NHS, Local Authority and Emergency services of the multi-layered impact that the availability, sale and consumption of alcohol is having on individuals and the communities across Lambeth.

Alcohol consumption in Lambeth is higher than the average for London and, as with smoking; action to reduce alcohol and substance misuse will improve health and wellbeing and reduce health inequalities. We play an active part in the Safer Lambeth Partnership, which incorporates the work of our drug and alcohol team. We take the lead for this work, ensuring that the needs of service users are met whilst helping to support a reduction in violent crime associated with drug and alcohol misuse.

- 17.5 percent of Lambeth's population consume more than the recommended limit.
- 20 percent binge drink.
- 5.5 percent consume more than twice the recommended alcohol limit. This includes dependent drinkers
- Alcohol-related ambulance callouts have doubled in the last five years

- The mortality rate due to alcohol misuse for males and females in Lambeth remains higher than that of London and England.
- Screening for alcohol misuse is part of the NHS Health Checks programme.

We continue to work with clients and staff at St Thomas' hospital and the wider community to improve alcohol care. During 2012/13 we have continued to develop the alcohol pathway by commissioning two Alcohol Recovery Centres both for an 8 week pilot: i) Medical Model at St Thomas' Hospital and ii) Social model at Clapham Methodist Church (The HUB)
This service will continue until the end of the financial year and is currently being evaluated with a view to ongoing provision in the new financial year
.
An alcohol health promotion booklet was distributed to all Lambeth GP practices to support them in identifying alcohol misuse and offering advice. A half-day awareness raising and training day was held in March at the Oval for a range of health and social care staff. Training on identification of alcohol misuse and brief advice for Lambeth staff was made available to front-line staff through our health promotion training programme.

To tackle alcohol misuse, our Alcohol Action Plan includes: identification and brief advice training for front-line staff in both community and hospital, improving the treatment capacity for dependent drinkers, and also working with the local authority for example by providing the health impact evidence to support saturation zoning of licensed premises in night-time economy areas.

Our new Health Goal target is that 90 percent of identified frontline staff will have received training in screening and brief intervention for alcohol misuse by 2015.

In partnership with the London Borough of Lambeth our drug and alcohol treatment providers and service user groups we have re-configured the community based Drug and Alcohol Treatment System to increase effectiveness, efficiency and equity. Lambeth's main specialist community based providers have been integrated into the Integrated Treatment Consortium. Integrated care pathways have been established to ensure that all care received is standardised and of high quality. Recovery is the underlying principle Operating across all services and the revised system will support service users to identify their goals and aspirations and to help them achieve these from the point of entry to the point of exit from the system. The engagement of carers and significant others continues to be a priority within the new model to further enhance the recovery potential of our service users.

2.3 Our Health Programmes - Improving Services

We have been delivering our Health Goals under four key main programmes of work: Planned Care, Unplanned Care, Mental Healthy and Staying Healthy. We have worked with local people, NHS partners and others to

- Promote healthy lifestyles and prevent ill health
- Improve the care or people with long term illnesses; supporting people to stay healthier longer
- Raise the quality of healthcare across the board
- Shift services into community based settings where it is safe and effective to do so in order to make them more convenient and accessible for patients

PLANNED CARE JOINT WITH SOUTHWARK	*UNPLANNED CARE JOINT WITH SOUTHWARK*	*MENTAL HEALTH*	*STAYING HEALTHY*
• **management of long term conditions (including HIV)**	• Primary Care	• Lambeth Living Well collaborative	• Tobacco and alcohol
• **early detection and secondary prevention**	• A&E/Urgent Care	• Forensic Services	• Adult and childhood obesity
• **management of elective care in the most appropriate settings**	• 111 number	• Payment by results	• Physical activity
• **shifting service provisions promoting appropriate referrals**	• Integrated Care	• Talking therapies and counselling	• Health checks
• **reducing inappropriate variability in care**	• Reablement	• Dementia	• Mental well being
• **Older People**			
	• Telemedicine		• Diabetes
	• End of Life Care		• Access to prevention

2.3.1 Planned Care

The focus of our Planned Care programme is to develop and deliver an outpatient strategy, which reduces the risk of premature mortality and improve the quality of life by sustaining the control of long term conditions (including HIV) and shifting service provision from unplanned to planned, and planned to prevention for people with long term conditions and key elective conditions. The programme is run jointly across Lambeth and Southwark and with Kings College Hospital and Guy's & St Thomas hospital and community services. Patients and users are engaged and inform service developments and monitoring of

services , thereby ensuring continuous improvement.

During 2012/13 we have:

- Commissioned new community based diabetes clinics supported by consultants and specialist nurses. We have developed training of GPs and Practice Nurses to improve their skills in working with people with diabetes. This includes specialist teams regularly visiting practices to discuss and review their patients with diabetes. All people newly diagnosed with diabetes are offered access to an education programme to enable them to manage their own condition with the advice and support of health services. This work is across Lambeth and Southwark and is supported by the Guy's & St Thomas' Charity Diabetes Modernisation Initiative
- Commissioned new respiratory services, particularly for people with Chronic Obstructive Pulmonary Disease (COPD). This includes support to prevent admissions to hospital as part of HomeWard, access to pulmonary rehabilitation, a programme to support patients manage their condition,. Improved and integrated assessment and management of home oxygen and support to patients. Commissioned a new team of nurses to support people diagnosed with heart failure, run education sessions for GPs and Practice Nurses, rolled out a pilot for six community pharmacies to support people with high blood pressure (hypertension).
- Developed referral guidelines, including advice on prescribing for GPs and nurses for common skin conditions and we have re-commissioned an eczema education programme run by Guy's and St Thomas' for parents of children with eczema to also have access to training.
- Developed referral guidelines for digestive and liver problems and associated education for GPs. We have asked patients for their views of heptology services and will incorporate this into future commissioning plans.
- Commissioned a community based service for headache management as part of the neurology pathway to be provided across Lambeth.
- Developed new referral guidelines for common gynaecology conditions for GPs and reviewed access to the emergency gynaecology unit at St Thomas' as many women were attending who could be treated more effectively elsewhere.
- Lambeth musculo-skeletal clinical assessment and treatment services have experienced an increase in referrals and activity, reducing attendance in traditional outpatient services. As a result the conversion rates from outpatient to surgery are very high suggesting the right patients are now being sent to hospital. A new total hip and knee replacement pathway has been developed for implementation in 2012/13
- Agreed a pathway and process for GPs to share the care of patients on disease modifying (DMARD) drugs for rheumatology conditions with local hospitals, thereby reducing the need for patients to have follow up attendances in hospital.
- Developed clinically-led peer to peer review of GP referrals to hospital across Lambeth to support GPs to discuss the quality and appropriateness of their referrals and raise awareness of suitable alternatives. This has led to an overall reduction in

the numbers of patients referred and increases in referrals to alternative community based services. On this basis we have decided not to develop a single referral management service.

- All hospital trusts have put in place waiting list access initiatives which have led to a reduction in the numbers of people waiting over 18 weeks from referral to treatment, particularly for orthopaedic surgery, bariatric surgery (gastric bypass and banding) and diagnostic services.

2.3.2 Unplanned Care

Our Unplanned Care Programme is run jointly with Southwark with the aim of improving the quality of care to reduce avoidable accident and emergency attendances and unplanned hospital admissions. Lambeth is working closely with local partners in the Southwark and Lambeth Integrated Care (SLICare) Programme an initiative involving King's Health Partners, Social Care and NHS Southwark, with Dr Adrian McLachlan, Lambeth Clinical Commissioning Collaborative Board Chair as the Joint Chair of the Programme Board. SLICare is supporting different services to work better together to provide a more joined up service for patients, with better health outcomes. The key objective of SLICare is to deliver increased value across the whole care system by:

- Joining up care around people, across providers.
- Identifying and managing people's care needs better and intervening earlier.
- Ensuring care is provided in the most appropriate setting, particularly at times of crisis.

The first area to be taken forward has been around frail elderly people and work on long-term conditions has just commenced.
As part of our support for this work Lambeth, jointly with Southwark, has continued to develop a range of community based services to avoid admission to hospital. These services include the enhanced rapid response service and the HomeWard, providing a 'virtual ward' experience in individuals homes in the South East Lambeth locality. These services will be built on in 2013/14 with development of the Long Term Conditions pathway.

We will continue to work with the ICP to develop creative ways of linking services together and improving outcomes for patients. The ICP has been successful in securing a bid for funding of £4.8m from Guy's and St Thomas' Charity to help support the development of integrated pathways over the next two years.

In 2012/13 we have:

- Developed a specification for the further development of GP and nurse led advice and assessment in St Thomas' A&E. This service will be procured in the next year, and the existing urgent care centre service is currently testing this approach. We

have introduced a Patient Advice and Liaison Service at the front of A&E to support people to access same day GP services, including supporting them to register with a GP. GPs have audited their patients attending A&E, particularly during surgery opening times to identify some of the reasons for increasing attendances. We have put in place access initiatives to reduce waiting times in A&E.

- A new Urgent Care Centre has been opened at St George's hospital used by many Lambeth residents in Clapham and Streatham. This replaces the Tooting Walk in Centre. NHS Southwark set up a new minor injury service at Guy's Hospital in the summer of 2012.
- Ran the 'Choose Well' campaign to encourage people to use the full range of services available when they feel unwell including self care, community pharmacy services and GP services.
- Procured a provider for the 111 urgent access telephone service across South East London. The new service will launch officially on the 28th February 2013. As part of this initiative a comprehensive directory of services has been developed so patients are signposted to the most appropriate place for their care.
- Completed the evaluation of the Home Ward and Enhanced Rapid Response services and will be rolling out the programmes across the borough in 2013/14.
- Carried out audit of emergency department attendances and admissions from nursing homes across Lambeth and Southwark
- Continued to focus on improvements in End of Life Care. This included training to prepare for the migration to the London wide Coordinate My Care Register which will replace the Gold Patient Electronic Register, the continuation of the programme to ensure all Lambeth nursing homes are Gold Standard Framework accredited by 2014, CQUINs measure in acute and community services to ensure patients wishes on EOLC are discussed and recorded on the EOLC register Training has been undertaken
- Continued to focus on improvements in intermediate care services this included participation in the National NHS Benchmarking Audit on Intermediate Care Services, the roll out of Enhanced Rapid Response and undertook engagement on centralisation of intermediate care beds at the Pulross Centre, further investment in community based continuing care services and the development of an Amputee Rehabilitation Unit at the Lambeth Community Care Centre.

In 2013/14 the CCG which has agreed to take this forward will:-

- Agree the model and work with providers to ensure the roll out of the Home-ward
- Have developed the new model of inpatient intermediate care and increased the capacity of community based intermediate care services
- Commissioned the new Amputee Rehabilitation Service at LCCC
- Continue to roll out GSF in nursing homes

- Work with the Southwark and Lambeth Integrated Care programme to ensure services are in place to reduce the number of admissions to hospital from care homes

2.3.3 Mental Health

Building on the work of the Lambeth Living Well Collaborative the Mental Health and Wellbeing Strategy and Development Plan was revised and updated to reflect the importance, not just of health and care services but also the need to support people to access universal services such as learning, work, housing and leisure if we are to be successful in achieving our objective of services being focused on recovery, early intervention and prevention.

- Better management of common mental health disorders in primary care and more talking therapies.
- Better treatment of severe mental illness through improved support and intervention and improved access to routine healthcare.
- Promote social inclusion and wellbeing, strengthening support to people on their road to recovery.
- Prevent mental illness rather than just treat it.
- Greater use of local rather than specialist services.
- Higher levels of patient satisfaction and experience

To increase responsiveness of services and engagement of black and minority ethnic client groups, investment has been continued in the black and minority ethnic community development worker programme, hosted by Southside Fanon. The Lambeth mental health personalisation project (personal health budgets) has agreed procedures and protocols including referral, safeguarding, finance and evaluation and has been assessed by the Department of Health to have made significant progress. Support planning has begun with a target of 20 people to be ready to access personal budgets in the first half of 2011/12.

VITAL LINK, the Lambeth user and carer led organisation hosted by the Metropolitan Support Trust has developed rapidly since its inception in November 2009 and users and carers have had a significantly greater input to mental health commissioning and service improvement programmes during 2012-13. This has evolved during 2012 into the development of Missing Link a peer support initiative aimed at supporting more effective service delivery and service design by including people with lived experience of mental illness.

The national dementia strategy is being implemented locally with action to increase awareness, detection and early interventions. A care pathway and service model for a joint Lambeth and Southwark Memory Service is in operation.

Work to improve services for people with severe mental illness has involved redesigning and developing care pathways and services across primary, community, social and secondary care and the shift from institutional care toward services in the community.

Lambeth's Wellbeing and Happiness Programme aims to promote the strengths and assets of all who live and work in Lambeth.

Mental Health Improvement Programme (MHIP)

This programme aims to accelerate progress on designing care pathways in order to improve clinical effectiveness, quality, and ease of access. There are five components to the programme:

- Transforming primary and community mental health services via Lambeth Living Well Collaborative
- Criminal justice and mental health project
- Payment by Results
- Integrated talking therapies
- Implementation of Dementia strategy

Transforming primary and community mental health services for people with severe mental illness

This work is being led by the Lambeth Living Well Collaborative (a partnership platform of users, carers, GPs, clinicians, providers and commissioners) which aims to use "co-production" as the operating framework for the delivery and commissioning of services and support provided for people with long term mental illness.

It has undertaken extensive engagement with users, carers and partners with over 15 events and 1600 people participating. This has resulted in broad agreement on a much improved service offer which it is currently implementing. This includes building capacity within primary care via the new primary care mental health support service (PASS); recovery focused provision within the Voluntary sector via the Community Options service; a more responsive and easier to navigate secondary care (SLaM); extensive development of peer support networks and the expansion of time banking across the borough. Progress achieved during 2012-13 includes:

Impact to date

- Over 200 people supported (400 referrals) by via the (Voluntary Sector provided) Community Options Team

- Over 150 people supported (190 referrals) via the Primary Care Support Service (hosted by GP practice)
- Living Well partnership Information Hub developed via VCS – opens February 2013
- One Recovery and support Plan agreed for whole system
- 3 locality Timebanking partnerships established
- 10 Peer Support initiatives established supporting service design and delivery by people with lived experience of mental illness.
- CQUIN (secondary care – "easy in easy out") targets aimed at improving interface between primary/secondary care beginning to impact
- 35 people have accessed a Personal Health Budget to support recovery and many more in the pipeline!
- Alliance Contracting development plan in place aimed at supporting integrated care
- Range of culture change initiatives including peer support, support planning, co design work

The overall aim is to support people to take control over their lives through recovery orientated personalised care and support and reduce the dependency on (especially) secondary care services – a common feature of mental health systems nationally as well as in Lambeth.

Following extensive co design work during 2012 two significant programmes of work are being prioritised for 2013/14 which forms a key element of the CCG's QIPP strategy. The first is the implementation of the Living Well Network which aims to ensure support is provided for people with serious mental illness much earlier through community based connected support arrangements across primary care, social care, VCS and secondary care. The objective is to keep people well, in their own home and reduce the need for specialist mental health services. The second element is to accelerate the progress made on supporting people to move on from secondary care to community based support. Whilst progress has been made as outlined above we need to increase the pace and scale. This includes plans to close an acute psychiatric ward and develop alternative crisis retreat provision.

Criminal justice and forensic services care pathway redesign

This focuses on developing early intervention and diversion (where appropriate) to address the high number of people with untreated mental illness in the criminal justice system and a key part of our QIPP strategy.

A new criminal justice mental health support service commenced may 2012 (funded by Guy's and St Thomas' Charity) targeting people in police custody and the courts. This is

signposting people to access appropriate support earlier and so avoid more expensive treatment and support following breakdown.

A range of community based step down and move on provision from secure services is being developed in collaboration with SlaM, social care and the VCS.

Payment by Results (PbR)

We are planning for the introduction of PbR in mental health from April 2014, with 2012/13 being a preparation year. This will enable, for the first time, transparency between service activity and costing. It will also enable a more sophisticated dialogue between commissioners and SLaM.

Integrated talking therapies

This project aims to improve access to, and the clinical effectiveness of, primary care talking therapies commissioned by Lambeth PCT. Older people and people from BME communities have previously been under-represented in services.

A decision to re-commission the various talking therapy services into one Lambeth-wide, integrated counselling and Improved Access to Psychological Therapy (IAPT) service was taken by the Lambeth Clinical Collaborative Commissioning Board (LCCCB).

Following a competitive tender process during 2012 the LCCCB approved the award of a 3 year contract for provision of integrated Talking Therapy services to a consortium led by SLaM. The service commenced November 2012 and will be reviewed by July 2013.

Mental Health Older adults including dementia strategy

During 2012/13 Lambeth continued to respond to national strategy and embed improved diagnosis, recognition and care for people with dementia and their carers.

There has been increased awareness of the Southwark and Lambeth Memory Service (SLMS) within general practice and consequently Lambeth has a high level of diagnosis of dementia when compared nationally (189th out of 211 CCGs). Refer to http://www.alzheimers.org.uk/dementiamap for an interactive national and local perspective.

CQUINs were established with acute and community health providers ensuring training for clinical and non-clinical staff in recognition of people with dementia and adjustments to care. CQUIN also included review and termination, if appropriate, of anti-psychotic prescribing in line with national guidance.

Assessment of older adult patients in mental health continuing care beds identified escalating physical health needs and the need to change the focus and environment of their care. This also achieved QIPP savings in year.

London Borough of Lambeth initiated a review of day services for people with dementia to include a comprehensive stakeholder consultation to inform potential redesign. Commissioners supported a bid by a voluntary support group to Guy's and St Thomas' Charity that will enable modelling of co-produced day services for people with dementia to enhance future day service provision and stimulate the provider market.

Commissioners worked with voluntary and community organisations to raise awareness regarding dementia, with a focus on BME groups, reflecting Lambeth's diverse population.

In 2013/14 further work in primary care is envisaged to improve diagnosis and will be supported by the recruitment of a Clinical Network Lead for Dementia (CNLD). The CNLD will work with identified practices to improve detection and care for people with dementia. Additionally a shared care protocol with SLMS is being devised to ensure ongoing review of anti-dementia drugs and prescribing can be carried out in primary care. Protected Learning Time for general practice will include identification, diagnosis, shared care and an understanding of the patient pathway for ongoing support for people with dementia and their carers.

Based on consultation and national best practice, London Borough of Lambeth will re-specify and implement redesign in day service provision for people with dementia and their carers.

Partnerships will be strengthened with voluntary sector for advice and support to people with dementia and their carers as well as working with King's Health Partnership (KHP) to ensure dementia is embedded in the Southwark and Lambeth Integrated Care programme.

Further shift of continuing care bed utilisation is envisaged and will provide £400k of QIPP savings.

2.3.4 Staying Healthy

Our core aim for our Staying Healthy Programme Lambeth PCT is to commission systematic health promotion and prevention services that have the effect of improving mortality rates, reducing morbidity and reducing the prevalence of key health risk factors.

The Staying Healthy programme is closely aligned with the Long-Term Conditions work and Joint Strategic Needs Assessment, and aims to encourage healthy lifestyles and reduce the risks of developing health conditions in the future. It covers a range of initiatives through which, working with partners, we seek to promote healthy lifestyles and prevent ill health.

NHS Vascular Health Checks

The NHS Vascular Health Checks programme is available across the borough. NHS Lambeth will exceed the Department of Health target set for 2012/13. During 2012/13 we have focused on improving the quality of the health checks, so there is a consistent approach across our practices. The joint specification developed across Lambeth, Lewisham and Southwark will give us an opportunity to benchmark ourselves against neighbouring boroughs. We will continue to work closely with our practices to support them where necessary. Screening for dementia will be incorporated within the NHS Vascular Health Checks from April 2013.

Lambeth Early Intervention and Prevention Service

Lambeth Early Intervention and Prevention Service has continued to embed during 2012/13 and supports the NHS Vascular Health Checks programme by providing a number of onward referral interventions including Exercise on Referral, NHS Vascular Health Checks for hard to reach patients, Health Trainers, Stop Smoking and brief Alcohol intervention services. NHS Lambeth commissions Guy's and St Thomas' Community Health Services to provide the Lambeth Early Intervention and Prevention Service.

Healthy Living Pharmacy

This initiative has given NHS Lambeth the opportunity to showcase community pharmacies enthusiasm for a greater role in improving the health and wellbeing of their communities and inform the future direction of travel for community pharmacy. NHS Lambeth now has 44 accredited pharmacies across the borough.

Healthy Living Pharmacies can support people to change their lifestyles, improving their health and wellbeing and with the potential to improve health outcomes and build the evidence base for pharmacy's contribution to public health.

Tobacco

We continue to provide leadership to the Lambeth Tobacco Control Alliance in working work together with partners to reduce smoking in the borough. Initiatives have included the working with children and young people to prevent them taking up smoking and supporting local implementation of the national cigarette vending machines regulation. We have worked with our local authority to prevent underage and illegal sales of tobacco products in the borough. Through a range of initiatives and working across a broad range of providers we are on track to achieve our Department of Health target for smoking quitters in 2012/13.

Childhood obesity

The NCMP results for 2011/12 academic year were published in 12/13. The 2011/12 Year 6 results showed the lowest proportion of overweight children and the highest proportion of healthy weight children recorded since the inception of the NCMP. Breastfeeding initiatives are working well, with coverage and prevalence of breastfeeding at 6-8wks consistently improved from 2011/12 rates. Lambeth CCG has been working in partnership throughout 12/13 with GSTT and LBL towards UNICEF Baby Friendly Initiative (BFI) and we are booked to be assessed for stage 1 accreditation in May 2013.
The various aspects of the Child healthy weight programme have progressed well including the specific Training to Children Centre staff and support to parents and the Level 1 multiagency training which is well attended by a range of professionals including social workers, teachers, GP's and other health workers. There were some initial difficulties around referrals to the Level 2&3 programmes, but they are now being resolved. The Level 3 quarterly monitoring meetings have highlighted some of the positive outcomes and learning from the engagement process with families including increased self-esteem and motivation. The presenting health, emotional and social issues to this service is extremely complex and requires intensive engagement with the families and child. Engagement of families with the service is working well and those on the programme appear committed to the process.

Childhood immunisation

Childhood immunisation has consistently improved throughout 12/13. The CCG worked with the Provider to develop a 12/13 CQUIN for Health visitors to improve MMR and Pre-school booster for 5yr olds. This has proven to be successful; MMR 1 has improved from 87.6% in Q1 to 91.3% in Q3. The pre-school booster, which is a more difficult cohort to engage, has improved from 71.6% at Q1 to 79.8% in Q3. Ensuring that Lambeth "looked after children" (LAC) are up to date with all their immunisations has also been a focus throughout the year. There are good rates of immunisation for younger children in care; the more challenging cohort has been the care leavers aged 16+. The LAC Nurse and Designated LAC doctor have been working closely with social care, improving recording

systems and information sharing protocols and holding drop in surgeries to immunise young people as well as raise awareness.

Teenage Pregnancy

The Under-18 conception rate now at its lowest ever rate - 34.8 per 1000 girls aged 15-17 (2011 data). The CCG re-commissioned Health and Wellbeing Programme in August 2012 based on success of last year. The Programme is being delivered in all Lambeth schools and targeted youth settings and comprises education programmes on sex and relationships, emotional health and wellbeing, substance misuse and violence. The Condom Distribution Scheme continues to be effective and 11, 555 condoms have already been distributed from Q1 - Q3 of 2012/13 with 700 new registrations and 1000 visits to easy access points.
900 young people accessed the sexual health outreach service from Q1 - Q3 - this service is available in schools, colleges and other youth settings. The main reasons for accessing the service have been for advice, post-TOP support and condom distribution. A Boys and Young Men's Programme has been re-commissioned in 12/13 and is being delivered in targeted youth settings (including the YOS and the PRU) and is being delivered to 60 young men. The Teens and Toddlers Programme continues to run in Lambeth with great results - 5 schools took part last year and another 5 schools are taking part this year. This programme is an inspirational programme which entails placing at-risk young women in a nursery environment to mentor a toddler. 150 staff members were trained in SRE level 1 in Q1 - Q3 and a training review is currently underway to ensure the training programme is effective and meets the needs of staff

2.3.5 Quality, innovation, productivity & prevention (QIPP) in Lambeth

The PCT had a challenging set of plans to address the gap between increasing demand for healthcare and the rate of growth of funding during 2012/13. We delivered 93% of our planned £15.255m QIPP schemes. Our strategy has been to focus on addressing the key health needs for people in Lambeth and to invest in prevention; to pursue earlier diagnosis; and improve support for people with long term conditions. The QIPP programme focused on :

- addressing the demand for acute care including both planned and unplanned care
- changing the service offer for people with serious and common mental illness
- provision of intermediate care
- development of improved services for people with long term conditions including health checks to identify people at risk of disease or at an early stage of disease to support them into treatment
- improved quality and effectiveness of prescribing
- efficiency of primary care and ensuring focus on early detection, better long term conditions support and prevention

support to individuals to quit smoking
- transform support to children who are obese and in preventing childhood obesity

2.3.6 The Future of Care Pathway Commissioning

This past year has been extremely busy as Lambeth PCT has helped prepare Lambeth for the future of healthcare commissioning. With the passing of the Health and Social Care Act 2012, the commissioning functions and duties of Lambeth PCT have, from 1 April 2013 transferred to:

- the NHS Lambeth Clinical Commissioning Group - commissioning routine and emergency hospital services, mental health and community health services and additional local services for GPs, pharmacists and opticians
- the NHS National Commissioning Board - commissioning of GP, dental, community pharmacy and optician services, specialist hospital and mental health services, health screening services and health visiting.
- The London Borough of Lambeth - commissioning services to support people to stay healthy and prevent ill health, services for older children, sexual health services and drug and alcohol services.

From the announcement of the proposed changes in commissioning health services, Lambeth CCG has been pro-active in working with the representatives of these new commissioning organisations and the London Borough of Lambeth to ensure a smooth and safe transition for the 1 April 2013 deadline. Lambeth CCGs full and unconditional authorisation by the NHS Commissioning Board in January 2013 is testament to the support the Lambeth PCT has offered the shadow CCG.

The PCT has long recognised the need to work with colleagues beyond Lambeth if we are to ensure a health system best able to deliver best quality healthcare for our patch. We have therefore worked in collaboration with neighbouring PCTs and other NHS colleagues across a wide range of responsibility. A recent and important example is the future of services provided by South London Healthcare Trust (SLHT). In January 2013 the Secretary of State published his decision on the future of SLHT following the recommendations of the Trust Special Administrator. This decision will affect health service configuration and provision across the whole of South East London. The recommendations notably include the dissolution of SLHT and changes to emergency services at Lewisham Hospital. NHS Lambeth CCG and NHS Southwark CCG will be working with King's Health Partners and others across the system to ensure continuity of care and improved services across the whole of South East London, including for Lambeth patients. In particular NHS Lambeth CCG, working with other CCGs in South East London will be taking forward the implementation of the three year Community Based Care Strategy which seeks to ensure:

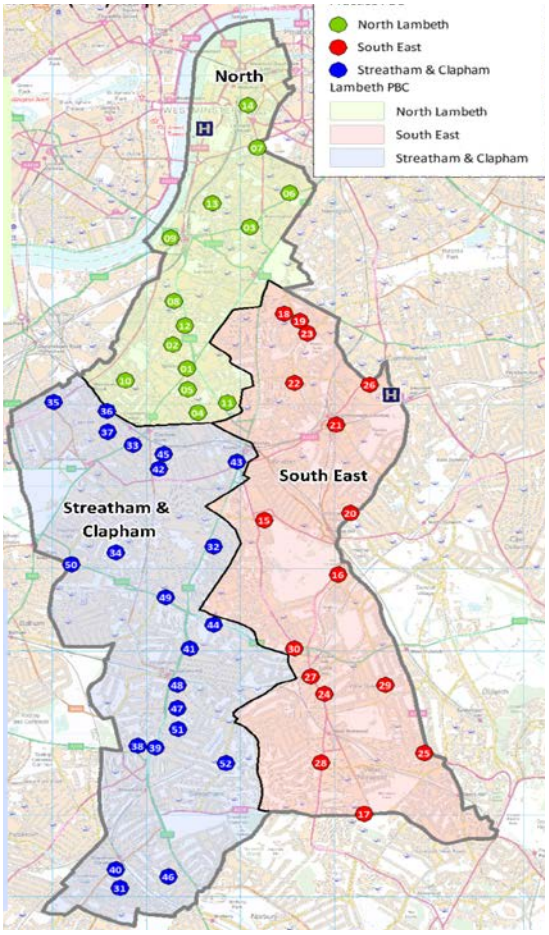
- support to help people manage their own health

- earlier intervention to prevent disease and better manage ill health and
- Community based services to support people at home

Finally the future of health service commissioning in Lambeth will need to take account of the report on Mid-Staffordshire NHST Trust published on February 2013 by Roberts Francis QC. This report challenges all parties involved in the provision, commissioning and scrutiny of health services. The main thrust of the report is a call to improve awareness of poor continuity of care in the NHS where it exists, as well as to encourage a culture which naturally challenges all instances of poor care. Lambeth CCG has developed a new Framework to commission for quality which has been tested through the authorisation process. This includes setting out the process for identifying early warnings and bringing together different sources of information. The approach will be iterative in nature with further reviews to ensure the framework takes account of the Francis recommendations as well as being aligned with the final Department of Health response to the document.

2.4 Working with Lambeth Localities

Lambeth is made up of three localities, North Lambeth, South East Lambeth and South West Lambeth.



Through locality working, we will continue to promote the shift of care out of hospitals and into primary care and community services, bringing services closer to where people live and work. GPs and other partners in localities will help people access the right services in the right place and at the right time. We also expect the change to generate improved value-for-money for the local NHS, helping us balance the increasing demand for health services and our assumptions about future funding.

This model of working will include:

- **Patient Choice**: help people make informed choices to lead healthier lives and to choose how and where to get treatment.

- **Personalisation:** personalised care for patients with long-term conditions, greater responsiveness to feedback from residents and patients, and greater efforts to meet the needs of different populations and 'hard to hear' groups.
- **Primary care and community health services:** enhance the quality of primary care and promote the shift of care from hospitals into the community, where it is safe and sensible to do so.

Each locality has access to shared premises that house a number of services that are right for that community such as tests to diagnose health conditions, minor surgery and outpatient clinics, surrounded by other local services such as GP surgeries, health centres and local pharmacies. In the last year we have made some significant progress in developing and delivering new facilities in our localities which will provide a range of health and social care facilities under one roof including the Clapham One Project and the Akerman Road Health Centre[6].

2.5 The Strategy for NHS South East London

We have worked together with the five other PCTs in South East London that came together from 1 April 2012 to form NHS South East London. This transitional organisational was established to achieve improved value for money through reduced administrative costs to support strategic transformation across South East London and to ensure ongoing delivery through to 2013 and the implementation of the new healthcare system.

Three main priorities were established for NHS South East London:

- Legacy - Improving health, quality and maintaining safety of local NHS services.
- Delivery - Sustaining an effective grip on finance, performance and QIPP.
- Reform - Proactively manage the transition to the new commissioning system.

The NHS South East London refreshed Commissioning Strategy Plan 'Better for you' for 2012/13 to 2014/15 sets out our collective vision for improving health and healthcare for the communities across the six boroughs we serve over the next three years.

More people in South East London will stay healthy, and every patient will experience joined-up healthcare which meets their needs in the most effective way.

This builds on previous plans and this past year's refresh has been developed from a local perspective and through collaboration across South East London in order to establish a coordinated approach to bringing about improvements for local people and achieve a sustainable health economy.

[6] See Section 5.5 for more information.

As part of South East London our ambition has been to meet the same strategic goals, in that every contact with the NHS and local public service partners, people are encouraged and enabled to positively manage their own health, in partnership with health professionals and their carers. The joint strategic goals aim to ensure:

1. Patients experience the NHS as a joined-up personalised service, rather than a disconnected set of services they are required to navigate.
2. Patients are treated fairly with dignity and the respect due to them at all times.
3. Clinical decision-making and healthcare delivery is in line with evidence-based best practice whilst offering value for money.
4. The logistics of healthcare delivery, within and across different care settings, are designed to meet patient clinical needs, whether long-term or acute, in the most effective way.

3. Improving Quality and Performance

Clinical Commissioning in Lambeth has been led by the Lambeth Clinical Commissioning Collaborative Board, engaging all 49 Lambeth practices across our three localities. The Board has taken on delegated authority and since December 2011 has had responsibility for all those aspects of health commissioning that will fall within the remit of Clinical Commissioning Groups (CCGs), on behalf of the PCT Board. The Lambeth Clinical Commissioning Collaborative Board membership is currently drawn from Lambeth practices through a selection and election process held in March 2011, non executive PCT Board members, executive leads and co-opted Board members from the London Borough of Lambeth, Lambeth LINk and from Kings Health Partners. Full membership is listed in section 6.

Board meetings are held in public every two months. Details are available on the website at www.lambethccg.nhs.uk

The NHS Constitution brings together in one place what patients, the public, and staff can expect from the NHS. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies, as well as private and third-sector providers supplying NHS services are now required by law to take account of the Constitution in their decisions and actions. The Government will have a legal duty to renew the Constitution every 10 years. No Government will be able to change the Constitution, and therefore how the NHS works, without the full involvement of staff, patients and the public. More information is available at www.nhs.uk/nhsconstitution

3.1 Commissioning services from health providers

3.1.1 Primary Care

Primary care services are commissioned from general practice, opticians, dentists and pharmacists. In Lambeth there are:

49 GP Practices
36 Dental practices
64 Community pharmacies
21 Opticians

Primary care contracting is undertaken by a single team covering NHS South East London. The team works with clinical commissioners and our staff to improve the quality of primary care services. A new London wide performance review framework has been implemented for general practice including information on the quality of services (visit www.myhealth.london.nhs.uk).

We have reviewed Personal Medical Services contracts and enhanced services to ensure value for money and equity of funding. We have also worked with practices to improve provision of care and health outcomes for people with long term conditions.

In Lambeth we have exceeded dental access targets set by NHS London and increased access to evening and weekend appointments. A national dental pilot for the new dental contract has been running with one of Lambeth's dental practices.

We are the only borough in London to pilot Healthy Living Pharmacies as part of a national programme. Around 75% of our community pharmacies will have been accredited by April 2013 and will provide a range of advice and support to improve the health of people in Lambeth.

3.1.2 Community Services

Lambeth community health services are provided by Guy's & St Thomas' NHS Community Services. Guy's and St Thomas' provide district and school nursing, health visiting, specialist child health, elderly care, intermediate & respite care and therapies such as physiotherapy, speech & language therapy and occupational therapy. It also runs:

- Specialist nursing service for sickle cell and thalassaemia.
- Community reproductive and sexual health services.
- The Three Boroughs community nursing team (healthcare to people with drug and alcohol problems, homeless adults, refugees etc).
- Supported discharge team, enabling older people to leave hospital care.

- Nutrition and dietetics advice and support.
- Foot care, including podiatric surgery.
- Lambeth health trainers to help residents adopt positive lifestyles.

Community services are delivered from GP surgeries, health centres, schools, children's centres and patients' homes. The trust also runs:

- Three inpatient centres: Lambeth Community Care Centre, Minnie Kidd House and Pulross.
- Specialist services for adults and older people with a physical health problem or disability at the Whittington centre in Streatham.
- The Gateway Clinic, a specialist Chinese medicine centre offering acupuncture and Chinese herbal medicine.

In addition there is a new heart failure services to improve the care of people with heart disease, Lambeth Early Intervention Services to provide support, advice and preventative services (including the specialist smoking cessation service) for people at risk of heart disease and for adults with obesity.

As part of the work of the Southwark and Lambeth Integrated Care Programme (SLICare) which works across the NHS and social care in Lambeth and Southwark we are leading on:

- HomeWards - services provided from people's homes to prevent admission to hospital and allow them to come home earlier from hospital.
- Enhanced rapid response – services to quickly rehabilitate people and prevent hospital admissions.

Both work closely with Lambeth Council re-ablement services which offer more intensive home care support to enable people to stay in their own homes for longer.

3.1.3 Hospital Care

Most Lambeth residents using the NHS are cared for by primary and community care. Where specialist care is needed they can use some of the best NHS hospitals in the country. Hospital care covers inpatient and outpatient services as well as day care and emergency care. We commission hospital care from a wide range of providers, and have over 30 separate hospital contracts in place. Most Lambeth patients however go to:

- Guy's and St Thomas' NHS Foundation Trust, made up of two of London's most famous teaching hospitals and the Evelina Children's Hospital.
- King's College Hospital NHS Foundation Trust, one of London's largest and busiest teaching hospitals, with an international reputation.

- St George's Healthcare NHS Trust, a teaching hospital which shares its main site with St George's University of London.

To ensure the delivery of high quality and effective services, we have a contracting assurance framework to assess trusts against quality standards. As part of this we:

- Have established the Southwark and Lambeth Integrated Care Programme, initially to improve services for older people across all settings and services.
- Agreed work programmes with King's Health Partners in areas such as cancer services, vascular services and specialist children's services.
- Are working closely with our local hospitals to further drive quality improvements by implementing a local quality framework.

We are working with local hospitals and primary and community services to move services into community settings when it is safe and effective to do so. Some of our successes in this area include:

- Provision of diagnostic services and treatment for diabetes at Gracefield Gardens in Streatham delivered by specialist staff from Guy's and St Thomas'.
- The new Akerman Road Centre in North Brixton which offers a wide range of health and social care services under one roof.
- Re-commissioned diabetes, cardio-vascular and respiratory services in the community to avoid people having to go to hospital unless they need high levels of specialist care.
- Enhanced support to people with long term conditions so that they can manage their own health and avoid hospital admissions.
- Provision of community based dermatology, headache services and the assessment of people with musculo-skeletal to avoid routine hospital attendances.
- Provision of urgent care services in the community to avoid people going to Accident and Emergency
- Improved stroke and major trauma care, based on standards of care established across London. Kings is designated as a Major Trauma Centre and Hyper Acute Stroke Unit.

There is also significant need for specialist health services organised on a London wide basis. These services are commissioned via the London Specialised Commissioning Group, and Lambeth is the biggest overall contributor to a number of services such as care for premature babies and specialist care for people with HIV and haemophilia. Quality is consistently high with regard to specialised services, with providers required to go through clinical accreditation.

3.1.4 Mental Health and Addictions Services

Services are commissioned from a range of providers in the public, independent and voluntary sectors, including a multi-agency consortium in HMP Brixton. The largest of these providers is South London and Maudsley NHS Foundation Trust (SLaM) which provides mental health services to over 8,000 Lambeth residents (including adult, adolescent and children) and Lambeth GPs have recorded around 22,000 people with depression.). SLaM provides comprehensive secondary and specialist mental health and addictions services to Lambeth. The Trust works in close collaboration with the Institute of Psychiatry to develop cutting edge clinical care.

3.1.5 Joint Commissioning Arrangements

During 2012/13 Lambeth PCT has continued its Section 75 Agreements with the London Borough of Lambeth and local Foundation Trusts for:

- Adult mental health services
- Integrated community equipment store
- Delayed discharges arrangements
- Free nursing care
- Deprivation of Liberty Safeguards.
- Integrated commissioning.

Lambeth PCT and the London Borough of Lambeth reviewed all Section 75 agreements and agreed that these continue until at least the end of the 2012/13 financial year. Following the appointment of a joint Director of Integrated commissioning to oversee commissioned services across both health and social care the integrated commissioning team has consolidated a number of services and arrangements covering:

- Children's Services
- Substance Misuse Services and
- Mental Health Services

Further work is underway around older people's services as well as possible streamlined processes across adult safeguarding and procurement; work which will be undertaken and completed under the new health service commissioning regime.

3.1.6 Future of clinical commissioning in Lambeth

The PCT has long recognised the need to work with colleagues beyond Lambeth to ensure a health system best able to deliver best quality healthcare for Lambeth. We have therefore worked in collaboration with neighbouring PCTs and other NHS colleagues

across a wide range of responsibilities. In January 2013 the Secretary of State published his decision on the future of South London Healthcare Trust (SLHT) following the recommendations of the Trust Special Administrator. This decision will affect health service configuration and provision across the whole of South East London. The recommendations notably include the dissolution of SLHT and changes to emergency services at Lewisham Hospital. The newly formed organisations, NHS Lambeth CCG and NHS Southwark CCG will be working with King's Health Partners and others across the system to ensure continuity of care and improved services across the whole of South East London, including for Lambeth patients. In particular NHS Lambeth CCG, working with other CCGs in South East London will be taking forward the implementation of the three year Community Based Care Strategy which seeks to ensure:

- support to help people manage their own health
- earlier intervention to prevent disease and better manage ill health and
- Community based services to support people at home.

3.2 Our Performance against National Standards

We have continued to improve performance of local services which are leading to better health outcomes for patients

Breastfeeding at 6-8 weeks: The latest position as at the end of December 2012 shows continued strong performance. Q3 performance shows coverage at 93.62% and prevalence at 73.25% compared to 89.9% coverage and 67.8% prevalence in 2011/12.

Four week smoking quitters: Latest year to date performance figures as at Q3 show 1602 smoking quitters, against a Q1, Q2 and Q3 target of 1595. The PCT is on track to meet this target of 2262. Final figures for 2012-13 will be published in May.

Childhood obesity: The latest available NCMP results for 2011/12 academic year have been published. Although year 6 prevalence is still higher than the regional average there has been a narrowing of the gap between Lambeth and London. The 2011/12 year 6 results showed the lowest proportion of overweight children and the highest proportion of health weight children recorded since the inception of the NCMP.

Dementia: Current performance on dementia diagnosis is 54.9% compared to the national average for England of 46% which ranks Lambeth CCG 21st (190 of 211) of CCGs.

NHS Health Checks: Performance on the number of eligible people offered Health Checks in Q3 remains strong achieving 7.6% against a quarterly trajectory of 5%. Further work is required to improve the number of people receiving health checks.

Chlamydia Screening: We continue to be ranked first in England as the highest screening primary care trust. In 2011/12 our PCT achieved 49.5% chlamydia screening coverage (of 15 to 24 year olds) in community testing (non-GUM) settings against a national target of 35%, with a positivity rate of 9.7%. This compares to a London average of 29.4% coverage and 5.7% positivity rate through community testing.

Access to NHS Dental Care Services: We exceeded the 2012/13 target to have 156,804 patients accessing NHS Dental services within a 24 month period. Latest performance data as at month 9 shows that 159,864 patients accessed NHS dental care which is 3,060 more than planned.

Mental Health It is expected that all mental health national targets for 2012/13 will be met. The target for the number of new cases of psychosis served by early intervention teams for 2012/13 is 90; we are on schedule to exceed this based on Month 9 figures, performance of 84 episodes.
The target number of Home Treatment episodes for 2012/13 is 888, we expect to exceed this based on performance at Month 9 which was 639.

The number of patients with improved access to psychological services is expected to be exceeded, our target for 2012/13 is 4420, we achieved 3644 at Month 9.

Cancer Waiting Time standards: Year to date performance data for Lambeth residents shows that all the cancer targets were met. Cancer waits performance across South East London has consistently been high with almost all the standards being met. The exception is the 62-day standard for treatment following urgent GP referral at Guy's & St Thomas' where performance has consistently been below the 85% standard (although this hasn't impacted on Lambeth residents). This is partly due to a persistent issue of late referrals being received by Guy's and St Thomas' from other hospitals, which use it as a cancer centre. The Trust is focused on eliminating all delays that are internal and within its control, with a specific focus on the urological pathway which has the highest number of breaches.

Improved access to Stroke Services: Latest Q3 figures show 90% of Lambeth patients suffering from a Transient Ischemic heart attack were assessed and treated within 24 hours against the standard of 60%. 86% of patients suffering a stroke spent at least 90 percent of their time on a stroke unit against the 80 percent standard.

A&E 4 hour waits: The threshold of 95% of patients being admitted, discharged or treated within 4 hours continues to be the main measure for assessing A&E performance. Outturn figures for 2012-13 confirm that the target was met by GSTT and KCH.

Referral to Treatment Times: The expectation is that 90% of admitted patients and 95% of non-admitted patients will receive their treatment within 18 weeks of a referral. These trajectories were met for GSTT and KCH.

Hospital Acquired Infections CDiff and MRSA: The Department of Health sets challenging targets for both MRSA and Clostridium Difficile Infection reduction. As at the end of February 2013 4 cases of MRSA have been recorded against a year end target of 4. Of these 4 cases 3 were not attributable to the Trusts (patients already presenting themselves at the Trust with MRSA). The PCT has met the CDifficile target, achieving 53 cases against a trajectory of 73.

2012/13 (Quarter 1 to Quarter 3)
National Performance Measures – Lambeth PCT

National Performance measures 2012-13	Operating Standard/ Target 11/12	Actual outturn 11/12	Operating Standard 12/13	Actual outturn 12/13	Time period of underlying data for 12/13	Traffic Light Year End Position
A&E 4 hours wait	95%	95.60%	95%	94.7	YTD Q3	
Category A Ambulance response within 8 minutes	75%	75.6%	75%	76.6%	YTD M8	
Category B Ambulance response within 19 minutes	95%	99.1%	95%	98.2%	YTD M8	
Cancer 2 week waits (all urgent GP referrals)	93%	97.10%	93%	96.50%	YTD M8	
Cancer 2 week wait (for all breast symptom referrals)	93%	96.80%	93%	97.70%	YTD M8	
Cancer 31 day wait from diagnosis to (first definitive) treatment	96%	98.40%	96%	98.20%	YTD M8	
Cancer 31 day wait from diagnosis to (subsequent surgical) treatment	94%	96.50%	94%	95.90%	YTD M8	
Cancer 31 day wait from diagnosis to (subsequent treatment) where that treatment was an anti cancer drug regime	98%	99.40%	98%	99.10%	YTD M8	
Cancer 31 day wait from diagnosis to (subsequent chemotherapy) treatment	94%	99.40%	94%	92.60%	YTD M8	
Cancer 62 day wait from urgent GP referral to treatment	85%	88.0%	85%	87.5%	YTD M8	
Cancer 62 day wait from urgent referral from national screening services to treatment	90%	94.7%	90%	88.9%	YTD M8	
Cancer 62 day wait from consultant (upgrade) referral to treatment	85%	87.9%	85%	88.2%	YTD M8	
Number of people receiving early intervention services	90	129	90	84	YTD M9	
Number of people receiving home treatment services	888	910	888	639	YTD M9	
RTT- admitted % within 18 weeks	90%	88.3%	90%	92.5%	YTD M9	
RTT - non-admitted % within 18 weeks	95%	97.4%	95%	98.4%	YTD M9	
RTT - incomplete % within 18 weeks	92%	89.3%	92%	93.7%	YTD M9	
Diagnostic Waits - % waiting more than 6 weeks	<1%	2.98%	<1%	3.2%	YTD M8	

MRSA	7	8	4	4	YTD M9	
Cdiff	73	110	73	44	YTD M9	
4 Smoking Quitters	1908	2353	2262	1009	YTD M6	
Coverage of NHS Health Checks - 40-74 offered health check	20%	28.8%	20%	21.3%	YTD M9	
Coverage of NHS Health Checks - 40-74 received health check	TBC	6.9%	TBC	3%	YTD M9	

3.3 Ensuring High Quality Services

Our approach to securing quality services rests upon firm foundations, and is further driven by the systems and processes in place to support individual, team and corporate accountability for delivering patient centred, safe and high quality care. Comprehensive reporting on patient safety issues is reported at each Board meeting and includes progress in a number of areas.

Assurance framework about the quality of services

The Lambeth PCT Board Assurance Framework (BAF) and Risk Register is the means by which we identify the risks to achieving our objectives. It sets out the actions required to reduce those risks to an acceptable level. This is constantly reviewed. High risks specific to community, mental health or hospital health services are followed up with providers and reviewed by a Board level Integrated Governance Committee meeting. A monthly update is provided to the Board and the full risk register is published with all public meeting papers.[7]

Health care providers are held to account for quality issues through regular quality meetings. Further information is provided in hospital provider published annual Quality Accounts available on their websites.

Risk Register

The Lambeth PCT corporate risk register is reviewed and updated monthly. Risks are scored according to the consequence and likelihood of the risk occurring on a 5x5 matrix. At 31 March 2013 there were 14 ‘significant’ risks (risk rating 12) and one ‘high’ risk (risk rating 16) relating to the achievement of four corporate objectives.

[7] See section 7 on Governance for more information on risk

The ‘high’ risk concerns the risk of our acute providers not meeting 18 week referral to treatment (RTT) targets. All risks have robust action plans in place. The action plan for the ‘high’ risk is monitored directly with acute providers.

The following is a link to Lambeth PCTs full BAF and Risk Register: http://www.webarchive.org.uk/wayback/archive/20130329030120/http://www.selondon.nhs.uk/your_local_nhs/lambeth/publications

Quality Alerts - The Commissioning for Quality Framework is an online tool used by GP practices as a means of raising concerns related to quality at service providers. The majority of concerns relate to communication issues between hospital services and GP practices which are often systemic. These are shared with relevant providers in order to seek a solution and then discussed at regular quality meetings which involve GPs and providers. The system was updated and relaunched in February 2013 to improve direct communications between GPs and hospital services when issues are raised. Concerns can now be raised by both the hospital provider and GPs.

Serious Incidents / Never Events - Serious Incidents are out of the ordinary and unexpected incidents or events with serious or likely to be serious consequences. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measure has been implemented by healthcare providers.

We recognise that high reporting organisations are high performing organisations, with a stronger safety culture. Provider reports on all incidents are reviewed through our Quality meetings. Additionally, National Patient Safety Agency guidance on serious incident management defines the responsibilities of Primary Care Trusts in monitoring serious incidents reported by their providers. We have established robust processes for the management of serious incidents which are in line with the national guidance and an agreed South East London Cluster policy. Serious incident requirements are included within provider contracts. Processes which have continued in the last year include:

- Regular provider serious incident monitoring meetings chaired by clinical commissioners
- Individual provider meetings to review and streamline serious incident processes
- Evaluation templates developed and implemented for reviewing the quality of serious incident reports
- Serious Incident report evaluation training provided to key staff within Lambeth PCT
- Lambeth CCG Internal Serious Incident Monitoring Group review all serious incidents prior to Board update submission
- Analysis of serious incidents and outcomes provided to the Board
- Regular feedback on Foundation Trusts on serious incidents.

During the year we were notified of nine never events by Guys and St Thomas' NHS Foundation Trust (GSTT). These included three surgical errors (retained swabs) and six wrong site surgery. The investigations and action plans are reviewed through the serious incident monitoring meetings and have been followed up directly with the GSTT Medical Director for assurance on actions. Two surgical error never events (retained swabs) involving Lambeth residents were reported by Kings College Hospital NHS Foundation Trust (KCH) during the year. These have been followed up through the Southwark PCT quality monitoring meetings.

Patient Satisfaction

We monitor patient satisfaction by gathering information from a huge range of sources including the National NHS Survey Programme and surveys carried out by our local NHS providers, as well as through our quality and complaints monitoring systems**.**

3.4 Patient Advice and Liaison Service/Complaints Service

Anyone can express a view or find out more about their local NHS through our Patient Advice and Liaison Service (PALs). The majority of these enquiries are handled through the national PALs helpline. Of those handled directly by Lambeth PCT during the year (approximately 44 per quarter) the majority concerned finding out GP referral processes and local GP practice information.

Anyone who is unhappy about the quality of service they receive can complain through the NHS complaints process. We take all complaints seriously, investigating them thoroughly and making it clear that a complaint will not affect the quality of care provided. At the end of January 2013 we had received 91 complaints and we acknowledged all of these within three working days. Most (81 percent) were responded to within 25 working days and those complex complaints which took longer to investigate, timescales were agreed with complainants.

All NHS organisations are expected to have their own procedures for dealing with complaints however; we also provide support to those wishing to make a complaint involving any of our independent contractors including GPs, Dentists, Opticians and Pharmacists. Our complaints policy was updated and approved in August 2012 to support the CCG Authorisation process and is compliant with the 'Principles for Remedy' published by the Parliamentary and Health Service Ombudsman in 2009. It can be found on our website at http://www.webarchive.org.uk/wayback/archive/20130329030120/http://www.selondon.nhs.uk/your_local_nhs/lambeth/publications

3.5 Emergency Planning

Lambeth PCT were a 'category one responder' to any emergency situation for 2012/13 which means that we have had defined roles and responsibilities under the Civil Contingencies Act 2004 with a requirement to act in accordance with the NHS Guidance for Emergency Planning 2005. Following authorisation as a Clinical Commissioning Group (CCG) and implementation of the updated NHS Act CCGs will be category two responders from 1 April 2013, providing support to the NHS Commissioning Board in any emergency situation rather than having lead responsibility.
During 2012/13 Lambeth PCT have been responsible for four key areas during a major incident:

- The co-ordination of NHS resources
- Mobilising healthcare for those affected by the incident, including psychological support
- The provision of prescription medicines to reception centres assisting acute (hospital) trusts to release patients from hospitals.
- As such, Lambeth PCT has a major role to play in any serious incident, such as floods, bad weather or a terrorist attack. Although all of us hope that incidents like these won't occur, Lambeth PCT works with colleagues across London to make sure that we are ready if the worst does happen.

We have plans in place to make sure health services continue to function in a crisis, and to let our staff and residents know what to do if they are affected and will continue to have plans to ensure the organisation can continue to function in a crisis from April. We also undertake emergency planning exercises to test our resilience. We actively work with our NHS and other partners including the Local Authority and Police to work together to respond to a major incident. This preparation was particularly important for the Olympics period.

4. WORKING WITH OTHERS

The PCT has built upon its strong history of partnership working in Lambeth in the belief that health in the borough can only be improved by working effectively with partners and fully engaging clinicians to work with local communities and patients to co-design services for the future.

Strong partnerships have been built between Lambeth PCT and:

4.1 Clinical/Care Professionals

Our success has been to use the skills and expertise of our clinicians throughout the Borough. Lambeth Clinical Commissioning Collaborative has been working across the three Lambeth localities with Board Members drawn from each. Each locality has its own structure and members meet on a regular basis to discuss the development of commissioning across the borough and review performance of local services. These locality arrangements have been developed over 2012/13 by engaging both clinicians and practice managers through learning sets whilst enhancing our communications, leadership and information to secure service improvement. We are committed to finding innovative and sustainable ways to build on our existing networks. The Lambeth Clinical Commissioning Network (LCCN) brings together the wider clinical and non clinical community (such as GPs, practice managers, nurses, pharmacists, opticians and social care colleagues) to support Lambeth Clinical Commissioning Collaborative Board's priorities. Anyone wishing to contribute to the work of the Clinical Commissioning Network in Lambeth can find out more on our website at: http://www.lambethccg.nhs.uk/GPZone/Pages/ClinicalNetworkArea.aspx

4.2 Lambeth Council

Lambeth Strategic Partnership

The Lambeth Local Strategic Partnership continues to work on implementing the plans of the cooperative borough. Our contribution to the work of the Children's Trust Board and the Safer Lambeth Partnership has continued to be reflected in our operational priorities and resulted in an inspection rating of Outstanding awarded by CQC and Ofsted for our arrangements for Children's Safeguarding and we have seen Significant Improvements in the engagement, individual outcomes and service user experience of drug and alcohol users as a result of the integration of our 4 main substance misuse services into a single service evidenced by a local service evaluation.

Health and Wellbeing Board

The new shadow Health and Wellbeing Board has met three times and the first annual Health and Wellbeing Summit was held at the Oval on 28th February 2013. The Board is led by Councillor Jim Dickson, cabinet member for Health and Wellbeing, with vice-chairs Councillor Rachel Heyward, Cabinet Member for Children and Families and Dr Adrian McLachlan, Chair of the Lambeth Clinical Commissioning Group Governing Body. Each meeting has seen increased participation by Lambeth residents as we work together to shape the Health and Wellbeing Strategy for the borough and identify the key priorities to improve health and wellbeing and reduce inequalities in Lambeth.

Health and Adult Services Scrutiny Committee

We continue to work closely with Lambeth Health and Adult Services Scrutiny Committee, engaging Lambeth's democratically elected members in the local implementation of national NHS reforms and welcomed examination of local plans and proposals for service change. We have presented papers and responded to questions at each meeting of the committee in 2012/13.

4.3 South East London

We are working across south east London with other partners including clinical commissioning groups to improve health and health outcomes.

- South East London wide Clinical Strategy Group to establish south-east London wide Commissioning approaches.
- The establishment of a strategic oversight group to consider issues of clinical strategy and transformation across Lambeth, Southwark and Lewisham in order to increase the impact of our collective working.
- Support the establishment of a South London wide Commissioning Support Unit that began to deliver services to shadow CCGs and PCTs from October 2012.
- Share programmes of work with Southwark clinical commissioners around planned and unplanned care.
- Developing a shared public health function with Southwark

4.4 Local Providers

We work in active partnership with our local provider partners, in particular King's Health Partners Academic Health Sciences Centre, to support redesigned and improved service quality as well as better organised and joined up pathways of care. A number of our most important initiatives are supported by the Guy's and St Thomas' Charity including the Diabetes Modernisation Initiative and Southwark and Lambeth Integrated Care (SLICare). The SLICare programme supports different services and providers to work better together and so provide a more joined up service for patients, together with better health outcomes. A major objective of SLICare is to deliver increased value across the whole care system by:

- Joining up care around the individual person and across providers.
- Identifying and managing a person's care needs better.
- Intervening earlier.
- Ensuring care is provided in the most appropriate setting, by the most appropriate person at the most appropriate time (notably during times of potential crises)

Lambeth Living Well Collaborative brings together Lambeth PCT with SLAM, social care, the voluntary sector and service users and carers to redesign care available to individuals with mental health conditions.

4.5 Public and patients

We have a proven track record of listening to feedback from local people and using what they tell us to ensure that decisions we make about healthcare are underpinned by a clear understanding of public views, concerns and aspirations.

Knowing what people think about existing health services in Lambeth is also vital to helping us improve patient experience in the future.

We work with the Local Authority Overview and Scrutiny Committee, the Lambeth Local Involvement Network (LINk) and voluntary groups to actively encourage members of the public to help us plan and buy the best high quality services possible.

Views of the public and patients are essential to us – otherwise how would we know whether the services we commission meet local needs?

We use a range of approaches to engage with Lambeth patients and the public to make the Government's call for 'no decision about me without me' a reality.

- We commission services that recognise and support people's own contribution to their health and that work in partnership with patients – such as the expert patient programme for people who have long-term health conditions and the peer support programme in mental health.
- We are working with our 51 GP practices to develop patient groups that can have a real influence in the surgery and beyond that to our Board room.
- We hold Board meetings in public and offer opportunities for people to ask questions.
- We have developed detailed plans in each of our major programmes of work to make sure we are hearing what Lambeth people want and need from their health services; we're working with HIV service users to remodel care and support services, and our work in the Lambeth Living Well Collaborative has been recognised nationally for pioneering a new model of commissioning, where service users are 'co-producers' of our plans and are recognised as much for their contributions as for their needs.
- Last July we spoke to 1,000 people visiting Lambeth Country Show about health and how it might be improved in Lambeth.

A full report on the detailed consultation and engagement work we have undertaken over the year can be found in our Duty to Engage report on our website: http://www.webarchive.org.uk/wayback/archive/20130329030120/http://www.selondon.nhs.uk/your_local_nhs/lambeth/publications

There are lots of ways patients, the public and our staff can get involved and tell us what they think. These include:

- Attending the South East London Joint Boards meetings which are held in public.

- Attending the Lambeth Clinical Commissioning Collaborative Board meetings and our Annual General Meeting, these are meetings held in public and dates and agendas for meetings are on our website at www.lambethccg.nhs.uk
- Join a patient or user involvement group at your GP surgery
- Join the Lambeth LINk, the Boroughs local involvement network. LINks aim to give people a stronger voice in how their health and social care services are delivered.
- Respond to our public consultations which are also published on our website.

Lambeth Involvement Network (LINk)

The Lambeth LINk is one of 150 statutory local involvement networks set up to make people's views known to those who run health and social care services. We have worked systematically with Lambeth LINk to develop ways in which residents and community organisations can comment on and influence how we plan and deliver healthcare across the borough. We have been to LINk meetings to talk about our strategic priorities and how we plan to improve health and reduce health inequalities for and with the people of Lambeth, and we always respond in a full and timely manner to questions and reports on specific issues of interest to the LINk membership. The LINk Chair is a co-opted member of the Lambeth Clinical Commissioning Collaborative Board, and LINk members have actively participated with us as part of the independent NHS Future Forum, which was established to advise the government on the implementation of NHS reforms.

We have supported the development of and were a co-signatory of the Lambeth LINk's submission to become a Local HealthWatch pathfinder.

4.6 Stakeholder Reference Groups

In April 2011 NHS South East London established three Stakeholder Reference Groups (SRGs) across South East London. One for Lambeth, Southwark and Lewisham boroughs one for Bexley, Bromley and Greenwich boroughs and a South East London wide group.

The SRGs have two main objectives:

- To improve the engagement plans of the local NHS and identify opportunities for strengthening engagement.

- To review the impact of any plans on patient choice.

The SRGs aim to improve relationships with stakeholders and ensure they are kept informed of changes in the local NHS. They are made up of representatives from the Local Involvement Networks (LINks), the voluntary sector, Council Overview and Scrutiny Chairs and officers, clinical commissioners, non executive directors and other representatives from across NHS South East London. Local provider organisations are also invited.

Achievements over the last year include:

- reviewing of a range of engagement plans relating to different service improvements and developments
- co-ordinating responses to national developments and processes, including the engagement requirements for Any Qualified Provider and the Trust Special Administrator's report on South London Hospitals Trust (SLHT) and the NHS in South East London
- improving relationships between clinical specialities and organisations.

5. MAKING IT HAPPEN

5.1 Our Staff

NHS south east London currently employs 753.45 full time equivalent (FTE) staff across five PCTs and one care trust. Following the last organisational change process in March 2011 which led to the creation of NHS South East London, new human resources (HR) team was formed. Staff in Lambeth receive HR expertise, advice and support from this central team together with workforce transformation support as we continue to develop our services towards delivering GP commissioning.

5.1.1 Staff Survey

As a result of the Health Act 2012, it was agreed that PCTs would not be subject to a Staff Survey in 2012.

5.1.2 Sickness absence

Monthly sickness absence reports include individual sickness absence trends. These are discussed with appropriate managers to ensure that the right support is provided to staff who are absent due to sickness to enable appropriate and timely returns to work.

The following sickness information relating to Lambeth PCT has been provided by Department of Health ESR system:

	2012-13 Number	2011-12 Number
Total Days Lost	**1,177**	**2,411**
Total Staff Years	**287**	**446**
Average working Days Lost	4.10	5.40

5.1.3 Training and Development

The NHS South East London Staff Development Programme was launched in September 2011 based on the training needs identified in personal development plans. This programme offers a range of learning and development opportunities for staff such as project management with the aim of supporting knowledge, skills and personal development particularly during a period of organisational change. The programme also ensures that all staff work in a safe and effective way and are up to date with their statutory and mandatory training. Staff can also apply for external training that is not covered by the programme

- 6 different training courses were offered to staff up to March 2013, arranged in 7 course sessions with a total of 85 places available
- 47 staff have had individual training fund requests approved.

Additionally, in March 2012, NHS South East London launched the "Piecing Together Change" programme designed specifically to help support staff during transition. The programme comprised of 85 workshops with a total of 1020 places available. The second part of the programme comprised of a series of one to one clinics providing additional support to staff affected by change. 126 slots of 1h 15 minutes were made available to staff.

5.1.4 Equalities for staff

As part of the development of the PCTs Equality objectives for 2012/2013, we have developed equality objectives for our staff and leadership. The purpose of setting these objectives is to strengthen our performance under the Public Sector Equality Duty (PSED) of the Equality Act 2010. The development of the equality objectives has been aligned to the outcome of our Equality Delivery System (EDS) grading for staff and leadership, the EDS goals and outcomes, as well as the priorities of the organisation in regards to people transition. The EDS grading for staff and the leadership of NHS South East London was carried out at the beginning of March 2012.

In November 2011, NHS South East London carried out a process of data cleansing of personal information currently held on the HR Electronic Staff Record (ESR) system. This process enabled us to consider the information that we had, identify any relevant information gaps, and to improve on non-personalised data to provide an initial equality and diversity baseline across the 5 PCTs & Care Trust in January 2012. The initial plan was to re-run the data collection process but due to transition, this work will now take place in February 2013 and will form the foundation for new organisations to build upon as part of the transfer arrangements on 1st April 2013.

NHS South East London is committed to preventing unlawful discrimination, advancing equality of opportunity and fostering good relations in a number of ways as detailed below.

Policies and procedures
In 2012, NHS South East London jointly agreed a single Organisational Change Management policy for all staff working in the 5 PCTs and Care Trust within the South East London Cluster. Where local change policy applies, this policy sets out the key stages of the process, the arrangements for pay protection, the support available for staff and the responsibilities of staff, managers and trade unions during periods of change.

One of the key objectives for developing this policy was to ensure equality and consistency with respect to all aspects of organisational change including pay protection. The majority of staff were matched to posts in receiving organisations in line with the 'National Policy for filling of posts in receiving organisations', CCGs and Local Authorities are however out of the scope of this policy and therefore the local change policy has been effective in ensuring that all staff across the 5 PCTs and Care Trust are treated consistently and fairly during the transition process.

Joint Staff Committee/Staff Partnership Forum
The SEL Staff Partnership Forum was set up in August 2011 as a bi-monthly forum involving recognised trade union representatives, Directors, Managing Directors and HR. The function of the group includes providing an environment for positive engagement with staff and their representatives, and the appropriate negotiation of terms and conditions that Agenda for Change allows to be open to local determination. The function also includes developing and ratifying employment policies and procedures. In addition to the Staff Partnership Forum, informal staff side meetings led by the Cluster Director of HR have taken place with staff side representatives on a fortnightly basis throughout the transition process.

5.2 Communicating with our staff

This year has been one of huge change and uncertainty for our staff. The clustering of five primary care trusts and one care trust in April 2011 resulted in a reduced workforce with staff working either within a borough based business support unit or within one of the main cluster wide departments of NHS South East London.

In Lambeth communicating with our staff has always been a priority, particularly during periods of uncertainty. We know that good communication is vital to the effective implementation of organisational change and a number of systems have been put in place to provide clear and consistent information to staff and enable them to contribute and engage in developments.

These include:

- regular staff communication through the staff fortnightly update and monthly management brief
- monthly staff briefings with the opportunity for questions and feedback
- interactive staff road shows for updates on key organisational change such as the development of a commissioning support service
- lunch and learn sessions
- updated databases to ensure all staff are included in regular communications
- establishment of an NHS South East London intranet and website
- video messages from the chief executive on key policy areas uploaded onto the staff intranet
- confidential comment box and email addresses for questions raised and responded to.

As part of our commitment to effective and productive conduct of employee relations we are part of a cluster wide joint partnership forum with staff side representatives. The purpose of the forum is to identify and facilitate workforce and employment business. This involves negotiation and consultation on policies and impending organisational changes. The forum meets on a bimonthly basis and is committed to continuously improving the working lives, health and wellbeing of staff.

During the last year, we have also worked collaboratively across London on communication campaigns and initiatives. This has enabled us to benefit from shared expertise and consistent public messaging around key organisational priorities. This includes a:

- London wide flu campaign encouraging people at risk to get vaccinated
- south east London Choose Well campaign based on patient insight and evaluation
- bowel cancer awareness campaign.

Effective communications will remain an important component of successfully moving to the new commissioning healthcare system in 2013.

5.3 ICT Services

ICT services for Lambeth are provided by South East London ICT Services, which formed by joining our local team with a shared ICT infrastructure service. This service is responsible for providing co-ordinated, consistent and value for money services across a range of NHS organisations in south east London. The shared service has prioritised a number of key areas for investment and improvement in 2012/13, including:

- The **Primary Care ICT Improvement Programme**, including
    - Implementing a standard three year rolling equipment refresh
    - Upgrading the N3 network for the majority of practices in South East London
    - Continuing and/or completing the rollout of mandated national systems such as the Summary Care Record and the Electronic Prescription Service
    - Upgrading 138 practices to the latest, hosted version of their GP clinical information system.
- A **core infrastructure upgrade**, including:
    - Upgrading the core data centre at Lower Marsh
    - Upgrading the infrastructure at Southwark's Tooley Street
    - Rationalising core infrastructure where this is the right thing to do, is cost effective, and improves the resilience and availability of the core network, and leads to a greener ICT infrastructure.
- Ensuring that the requirements associated with the **Handover and Closure** programme are delivered, including ensuring that:
    - staff can continue to access their emails by migrating their accounts to their new host body
    - smartcards controls are in place
    - all staff leavers system access rights are managed and/or deleted.

The ICT service will be provided by the South London Commissioning Support Unit in 2013/14. The CSU has developed a suite of strategies that further sets out improvements to the ICT service for NHS and other organisations in South East London, including:

- **Primary Care ICT Strategy:** to complete the rollout of mandated national systems such as the Summary Care Record, and to set out the deployment plan to meet requirements set out in the 2013/14 Operating Plan, including giving patients improved access to their medical records
- **Infrastructure Strategy**: to drive and deliver further improvements in the core infrastructure in South East London, including working with estates leads in Propco to deliver a fit for purpose network, and to further rollout secure remote working solutions for GPs, CCG and other staff, and
- **Capital programme:** a bid for funding has been submitted that will build on these two strategies, as well as focus on looking at the feasibility of introducing new ways of working such as exploiting the telehealth/telemedicine markets.

The CSU will continue to work with its partners to manage and deliver a portfolio of projects in 2013/14 and beyond, including the delivery of a number of estates projects such as Norwood Hall and the Integrated Care Programme.

5.4 Protecting your information

To provide the best possible healthcare services, NHS organisations collect sensitive and/or confidential information, often called Personal Identifiable Data (PID). The key elements of Information Governance set the standards to ensure that this information is dealt with legally, securely, efficiently and effectively. Throughout this year we have focused on the management and preparation of change in the NHS to ensure continuity of service and appropriate controls around patient information. All our staff have to undertake Information Governance training and we continue to be committed to the standards set out by the Care Record Guarantee and the Information Governance Toolkit.

We continue to work hard to ensure the security of patient information and maintain appropriate access. We are reviewing current ways of working as well as support new innovations to ensure that appropriate controls and security are in place. Along with these changes we are keeping local patients informed about how their information is being used to deliver their healthcare and manage the NHS.

Areas of focus during 2011/12 and 2012/13 include:

- Records management in response to Department of Health guidance published in October 2011.
- Information security – ensuring that patient information continues to be handled safely and securely.
- Registration Authority – ensuring there is an appropriate framework in place that meets NHS and legal requirements to provide, monitor and manage access to NHS Care Record Service systems such as GP clinical systems.

We have put in place arrangements for investigating if there is any potential breach of our procedures or policies. As part of this process, we consider whether we need to report breaches to NHS London and the independent Information Commissioner's Office.

Statement on public information

Lambeth PCT complies with HM Treasury's guidance on setting charges for information in 'Managing Public Money'.

5.5 Serious incidents in relation to information governance

Staff are encouraged to report incidents and 'near miss' events so they can be investigated and so that we can reduce the risk of such incidents in future. We are also legally required to assess whether any incident constitutes a serious incident.

A serious incident is something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service.

In the context of information governance, a serious incident is defined as any incident involving the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals. Incidents of this type must be reported to the Department of Health and the Information Commissioner's Office. During 2012/13 no incidents of this type were reported..

5.6 Investing in Premises

5.6.1 Transfer of Estates and staff to NHS Property Services Ltd.

NHS Property Services Ltd has been set up to maintain, manage and develop around 3,600 NHS facilities, from GP Practices to administrative buildings. The NHS SEL Estates team are preparing for the transfer of existing roles to NHS PS prior to the launch of the new organisation in April 2013. The team will remain at Lower Marsh and will initially continue to undertake the current range of services provided.

5.6.2 Lambeth Estates

2012/13 has been a year of further significant investment in the Lambeth community estate, with investment to reduce backlog maintenance being the main priority. Funding has also been secured and approved to address statutory, contractual and CQC identified priorities across Lambeth GP sites.

The Akerman Health Centre opened to patients in August 2012, and was officially opened in November 2012 by Kate Hoey MP.

Financial Close was achieved for the development of the Norwood Health and Leisure Centre in April 2012, which is being developed in partnership with Lambeth Council. The Centre is to open in Spring 2014.

A Business Case for the development of new premises for the Palace Road Practice was approved by the Capital Strategy Group, subject to the approval of the February 2013 Lambeth BSU Integrated Governance Committee.
Railton Road clinic has been approved as surplus to requirements, and a Business Case for the disposal of the Clinic is currently being prepared. This follows the transfer of services to the new Akerman Health Centre.

Considerable time has been given to DoH completing due diligence returns in support of the transfer of the estate planned for 31st March 2013 to community service providers,

Community Health Partnerships (LIFT) or to NHS Property Services Ltd. Additional resources have been made available to progress where possible, outstanding TCS and other tenant leases prior to transfer.

5.6.3 Sustainability Report

Environmental sustainability is an important NHS priority. During 2011/12 NHS South East London PCTs have concluded a number of property disposals for sites which did not meet healthcare requirements. This has seen older, less energy efficient stock sold. New buildings brought opened in the year have conformed to the BREEAM requirements, providing better quality patient and staff environments as well as more efficient infrastructure.

6. GOVERNANCE

Governance is about doing the right thing, running an organisation well, providing better services, identifying and managing risks and being able to provide assurance that these things are being done well.

6.1 Managing our organisation

On 1 April 2011, NHS South East London was established as a transitional organisation to take us through to 2013 and the implementation of the new healthcare system.

The NHS South East London Joint Boards are six individual PCT/Care Trust Boards that work together as one entity, undertaking the duties that are enshrined in law relating to the governance of Primary Care Trusts and Care Trusts, but fulfilling them in a slightly different way. Certain mandatory positions on the Boards, such as the Chair, Audit Chair and Chief Executive, are fulfilled by the same individual across all of the Boards, while other positions are taken by local Business Support Units Managing Directors and locally-focused non-executive directors. Fulfilling the same legal duties as PCT Boards have always had, the Joint Boards focus on developing strategies and priorities for the entirety of south east London, ensuring that the borough clinical commissioning committees are fulfilling their duties, in accordance with what is delegated to them.

From May 2012 the Joint Boards met every two months, in public. All meetings were quorate for all Boards. Board papers and details of meetings are available at www.selondon.nhs.uk

The Joint Boards are supported by NHS South East London a single shared corporate management team and six borough-based Business Support Units. There is a single accountable officer and executive team made up of six directors, a chief nurse and medical director, who work with the managing directors of the six BSUs.

During 2012/13, the Lambeth PCT Board consisted of:

Name	Position
Caroline Hewitt	Chair, NHS South East London
Steven Corbishley	Non Executive Director
Andrew Kenworthy	Chief Executive NHS South East London (until 4/9/12)[1]
Christine Craig	Interim Chief Executive NHS South East London (from 3/9/12)
Richard Chapman	Acting Director of Finance[2]
Malcolm Dennett	Interim Director of Finance (from 14/11/12)
Alison Tonge	Interim Director of Finance (from 6/8/12 to 15/11/12)
Jane Schofield	Director of Operations and Joint Deputy Chief Executive
Gill Galliano	Director of Development and Joint Deputy Chief Executive (until 30/7/12)
Donna Kinnair	Director of Nursing (until 1/10/12)
Jane Clegg	Interim Director of Nursing (from 1/10/12)
Sue Gallagher	Non Executive Director
Richard Gibbs	Non Executive Director
Graham Laylee	Non Executive Director
Rona Nicholson	Non Executive Director
Robert Park	Non Executive Director

David Whiting	Non Executive Director
Dr Ruth Wallis	Director of Public Health (from September 2012)
Dr Adrian McLaclan	Chair, Southwark Clinical Commissioning Group
Andrew Eyres	Managing Director, Southwark Business Support Unit

A full Register of the Interests of the Board of Directors is provided below.

Board Members Register of interests

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
Steven Corbishley	BT	A small number of shares of insignificant value	Nil
Susan Gallagher	Guy's and St Thomas' Charity	Trustee No remuneration paid	Self employed executive coach, facilitator and development consultant Husband a consultant oncologist at the Barts Health NHS Trust
	Guy's and St Thomas' Foundation Trust	Stakeholder governor	
Richard Gibbs	PHAST, a provider of public health consultancy to NHS bodies	Associate Consultant Value: None Materiality: Negligible since I avoid involvement with PHAST work in SE London	Nil
	Pembroke House, a charity helping deprived children in Walworth	Trustee No remuneration paid	
Caroline Hewitt	Withers LLP	Husband is partner in law firm whose clients include some NHS organisations. Remuneration: benefits from profit share	Nil
	VSO UK/VSO International	Member of Audit Committee No remuneration paid	
	King's College Hospital Charity	Trustee No remuneration paid	
Graham Laylee	ECT Venues Ltd – from time to time provides conference	Non Executive Director and small shareholder. Remuneration paid	Nil

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
	rooms for NHS organisations.		
Rona Nicholson	None	None	I am an Executive Director of Hanover Housing Association which operates in South East London and holds supporting people contracts with a number of Local Authorities
Robert Park	Cambridge House	Trustee No remuneration paid	Nil
David Whiting	Whiting & Birch Ltd	Director & Co Owner 50% shareholding Remuneration paid	Occasional sales of books and journals to NHS bodies which are largely indirect and through agencies. Working relationship with academics and others who may be employed in the NHS, or undertake research in the NHS. Publishing activities on behalf of professional organisations and academic bodies (non in the UK).
Richard Chapman	None	None	Nil
Ann-Marie Connolly (left)	None	None	Nil
Gill Galliano (left)	PCC CIC (Social Enterprise)	Trustee	Nil
Andrew Kenworthy	Diabetes UK Alzheimer's Society British Heart Foundation	Fund-raising for these organisations Wife – Consultancy business, training health professionals on cardio-vascular health and stroke for health communities/organisations across the UK	Nil
Christina Craig	None	None	Nil
Donna Kinnair	Royal College of Nursing Publications	Consultant Editor Expenses paid	Nil
	CWfI (Mouchell)	Board Member No remuneration paid	
	Walworth Academy	School Governor No remuneration paid	
Jane Clegg			
Jane	None	None	Nil

NAME	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests
Schofield			
Malcolm Dennett			
Amr Zeineldine	Aylesbury Partnership General Practice Membership of SELDOC	Partner (GP Principal) 20% shareholder Remuneration paid	Director of Aylesbury Medical Services Ltd providing Community Dermatology in Southwark
Andrew Bland	None	None	Nil
Ruth Wallis	Lambeth Local Authority Southwark Local Authority Lambeth CCG Southwark CCG	Joint Director	Nil

Board Committees:

Lambeth Clinical Commissioning Collaborative Board

The Local Clinical Commissioning Committees are the fore-runners to the Clinical Commissioning Groups which are under development and the Government expects will replace PCTs as the commissioners of local health services in 2013. These clinically-led bodies, supported by BSUs, identify local healthcare needs and prioritise commissioning accordingly. They also undertake the duties of the Professional Executive Committees (PECs) and provide oversight of local performance.

The Lambeth Clinical Commissioning Collaborative Board is chaired by Dr Adrian McLachlan. The membership is:

- North Locality member – Dr John Balazs (also Vice Chair)
- North Locality member – Dr Raj Mitra
- South West Locality member – Dr Ray Walsh
- South West Locality member – Ruth Jeffery
- South East Locality member and “111” member – Dr Patricia Kirkman (also Vice Chair)
- South East Locality member – Dr Gillian Ellsbury
- Lambeth BSU Managing Director – Andrew Eyres
- Director of Public Health (joint with London Borough of Lambeth) – Dr Ruth Wallis
- PCT Non Executive Director (NED) – Graham Laylee
- PCT Non Executive Director (NED) – Sue Gallagher
- Secondary Care Clinician – DR Suparna Das

- Nurse – Prof Ami David

Co-opted Members:

- London Borough of Lambeth Representative – Jo Cleary (co-opted member with voting rights)
- LINk Representative – Nicola Kingston (co-opted member with no voting rights)
- Secondary Care Representative – John Moxham, King's Health Partners (co-opted member with no voting rights)

In Attendance:

- Director of Integrated Commissioning (joint with London Borough of Lambeth) – Helen Charlesworth-May
- Director of Care Pathway Commissioning – Moira McGrath
- Director of Corporate Affairs and Human Resources – Una Dalton
- Chief Financial Officer – Christine Caton
- Clinical Network lead – Ash Soni

Register of interests of LCCCB members:

Name	Title	Interests	Remuneration
Adrian McLachlan	**LCCCB Chair, Lambeth PCT Board Member**	▪ Board Director and Board Member of SaCH (Ltd co.) ▪ GP Facilitator at Three Boroughs Primary Healthcare Team ▪ Chair Primary Care Substance Misuse Advisory Group ▪ Partner at Hetherington Group Practice which includes membership of SELDOC ▪ Member of Lambeth Living Well Collaborative.	**£55,952 per annum**
John Balazs	**LCCCB Vice Chair, Clinical Member and North Locality Representative**	▪ Chair of the South East London Cardiac and Stroke Network's Prevention Workstream ▪ Chair North Lambeth Locality ▪ Married to Dr Jenny Law - Chair of Lambeth LMC/Partner at Mawbey Brough ▪ Partner in the Binfield Road General Practice which includes membership of SELDOC ▪ Member of the GSTT Charity Major Funding Committee	**£27,976 per annum**
Patricia Kirkman	**LCCCB Vice Chair, Clinical Member and**	▪ GP Partner at Tulse Hill Practice which includes membership of	**£27,976 per annum**

Name	Title	Interests	Remuneration
	South East Locality Representative	SELDOC	
Gillian Ellsbury	**LCCCB Clinical Member and South East Locality Representative**	▪ GP Partner at Paxton Green Group Practice which includes membership of SELDOC ▪ GP Trainer London Deanery	**£27,976 per annum**
Ruth Jeffery	**LCCCB Clinical Member and South West Locality Representative**	▪ Advanced Nurse Practitioner and Lead Nurse at Dr Curran and Partners ▪ Active member of St Stephen's C/E church SW12, with close connections to The Weir Link community centre and Futures Theatre Company (educational drama). ▪ Visiting speaker at St George's Hospital in the interests of VTE prevention.	**£27,976 per annum**
Rajive Mitra	**LCCCB Clinical Member and North Locality Representative**	▪ GP Partner at Lambeth Walk Group Practice which includes membership of SELDOC ▪ Lambeth Walk Group Practice – Contract holder for Lambeth Community Headache Clinic ▪ GP Trainer London Deanery ▪ Kings College London Undergraduate teacher ▪ Member of the London Primary Care Research Network	**£27,976 per annum**
Redmond Walsh	**LCCCB Clinical Member and South West Locality Representative**	▪ GP Principal at Clapham Family Practice which includes membership of SELDOC ▪ Chair Streatham and Clapham PBC Consortium ▪ Chair Streatham and Clapham Health Ltd ▪ Director PFGPS Ltd ▪ Clinical Director : SPMS Clapham NHS ▪ Member Primary care Substance Misuse Primary Care Support Group ▪ Member of London HIV Expert Advisory Group ▪ Tutor Final year medical Students ▪ Member of national advisory group for Sexually Transmitted Infections Foundation Course	**£27,976 per annum**

Name	Title	Interests	Remuneration
		▪ Lecturer for KCH sexually Transmitted Infection Foundation Course ▪ Member of the LSL HIV prevention Steering Group ▪ Member of Lambeth Living Well Collaborative.	
Andrew Eyres	**Managing Director, Lambeth PCT Board Member**	▪ Married to Jill Lockett, Director of Performance and Delivery, King's Health Partners ▪ Lambeth PCT Stakeholder Member of South London and Maudsley NHS Foundation Trust Members Council ▪ Director representing the Lambeth, Southwark and Lewisham PCT's shareholding interests for the following LIFT companies: ▪ Building Better Health – Lambeth Southwark Lewisham Limited ▪ Building Better Health – Lambeth Southwark Lewisham (Holdco 2) Limited ▪ Building Better Health – Lambeth Southwark Lewisham (Holdco 3) Limited ▪ Building Better Health – Lambeth Southwark Lewisham (Fundco 2) Limited ▪ Building Better Health – Lambeth Southwark Lewisham (Fundco 3) Limited ▪ Building Better Health – LSL (Fundco Tranche 1) Limited ▪ Building Better Health – LSL (Fundco Holdco Tranche 1) Limited ▪ Building Better Health – LSL Bid Cost Holdco Limited ▪ Building Better Health – LSL Bid Cost Limited	**£112, 417.52 per annum**
Ruth Wallis	**Director of Public Health (joint with LB Lambeth), Lambeth PCT Board Member**	▪ London Representative – AD's PH	**£147, 299.68 per annum**
Sue Gallagher	**Non Executive Director – Lambeth PCT Board Member**	▪ Self Employed Executive Coach, Facilitator and Development Consultant	**£10,534 per annum**

Name	Title	Interests	Remuneration
		▪ Working on a freelance basis with various organisations in the NHS, parts of the DH and other sectors. ▪ Married to a Consultant Oncologist, Dr Chris Gallagher, employed at the Royal London Hospitals NHS Trust ▪ Voluntary work with Teach First ▪ Trustee for Guys and St Thomas' Charity ▪ Stakeholder Governor of Guys and St Thomas Hospitals FT ▪ NED on the NHS Lewisham and NHS Southwark Boards	
Graham Laylee	**Non Executive Director – Lambeth PCT Board Member**	▪ Non Executive Director of and small shareholder in ETC Venues Ltd ▪ NED on the NHS Lewisham and NHS Southwark Boards	**£10,534 per annum**

LCCCB Co-opted Members and Attendees

Name	Title	Organisation	Interests
Jo Cleary	**Co-Opted Member (Voting)**	**London Borough of Lambeth – Executive Director (Local Authority)**	▪ Honorary Treasurer and Trustee of Association of Directors of Adult Social Services; Chair of Workforce Development Network ▪ Board Member of National Skills Academy for Social Care ▪ Member of Social Work Reform Board ▪ Member of the Interim Board of the College of Social Work ▪ Chair of Lambeth Adult Safeguarding Adults Board ▪ Executive Director of L.B Lambeth
Nicola Kingston	**Co-Opted Member (non-voting)**	**Lambeth LINk**	▪ Employee of NHS Hammersmith and Fulham - Public Health Manager ▪ Co Chair of Lambeth LINk- volunteer position ▪ Member of the Patient and Public Advisory Group (PPAG) for NHS London (was Health care for London), which includes a £25 per meeting requested by NHSL, honoraria which I donate to charity.

Name	Title	Organisation	Interests
John Moxham	**Secondary Care Co-Opted Member (non voting)**	**King's Health Partners**	▪ Director of Clinical Strategy, King's Health Partners ▪ Professor of Respiratory Medicine, King's College London ▪ Consultant Physician, King's College Hospital ▪ Chair of Board of Trustees, Action on Smoking and Health (ASH). ▪ Member of the GSTT Charity Major Funding Committee
Christine Caton	**Chief Financial Officer**	**Lambeth PCT**	▪ Nil
Helen Charlesworth-May	**Director of Integrated Commissioning**	**Lambeth PCT/London Borough of Lambeth**	▪ London Borough of Lambeth- Divisional Director
Una Dalton	**Director of Human Resources and Corporate Affairs**	**Lambeth PCT**	▪ Director of Human Resources, NHS South East London Cluster - 2 days a week.
Moira McGrath	**Director of Care Pathway Commissioning**	**Lambeth PCT**	▪ Nil
Ashok Soni	**Clinical Network Development Lead**	**Lambeth PCT**	▪ Director of Copes Pharmacy Ltd ▪ Director of Soni Properties (UK) Ltd. Owner of freeholds of 570 and 572 Streatham High Road, London SW16 3QQ. ▪ Chair of Pfizer Pharmacy Advisory Board ▪ Vice Chair of London School of Pharmacy Council of Governors ▪ Member of the NHS Future Forum
Azhar Ala	**In Attendance as LMC Observer**	**LMC**	▪ Partner with Grafton Square Surgery, Dr Howard Freeman and Partners in Lambeth, Wandsworth and Merton. ▪ Member Lambeth Local Medical Committee ▪ Locality Lead South West Lambeth ▪ Honorary Clinician Renal Unit St Georges Hospital , Lambeth Outreach Clinic (South West Locality)

Name	Title	Organisation	Interests
			▪ Director Streatham and Clapham Health Ltd

Joint Audit Committee

The Joint Audit Committees fulfils the statutory audit functions required of PCTs and Care Trusts, ensuring that the governance and machinery of the PCTs function as it should. Their work programme includes reviewing governance arrangements (including Information Governance), assurance mechanisms including the work of internal and external audit, local counter fraud services, debt and waiver management, and reviewing the Board Assurance Framework to make sure that corporate objectives and organisational risks are properly addressed
Chair: Steven Corbishley
Executive Members: Marie Farrell, Director of Finance/Richard Chapman, Acting Director of Finance and Gill Galliano, Director of Development and Joint Deputy Chief Executive
Non-Executive Members: Keith Wood, Harvey Guntrip, Graham Laylee, Rona Nicholson, Robert Park and Jeremy Fraser

Joint Performance, Finance and QIPP Committee

Where the Joint Audit Committees ensures that the internal processes of the cluster are robust, the Joint Performance, Finance and QIPP Committees ensures that the work that the cluster actually undertakes is on track and delivering across the entire scope of its duties.
Chair: Graham Laylee
Executive Members: Marie Farrell, Director of Finance/Richard Chapman, Acting Director of Finance and Jane Schofield, Director of Operations
Non-Executive Members: Rona Nicholson, Jeremy Fraser, Richard Gibbs, Jim Gunner, Keith Wood, John Davey and Caroline Hewitt

Joint Quality and Safety Committee

The Joint Quality and Safety Committees oversees the proper functioning of the healthcare delivery aspects of our work; in contrast to the more universal processes of good governance overseen by the other committees, they will look into aspects of patient safety and commissioned services outcomes.
Chair: Susan Free
Executive Members: Jane Fryer, Medical Director, Ann-Marie Connolly, Director of Public Health and Donna Kinnair, Director of Nursing
Non-Executive Members: David Whiting, Robert Park, Sue Gallagher, Harvey Guntrip, Paul Cutler, Eileen Pallen, Caroline Hewitt, Eileen Pallen/John Davey (local authority), GP leads including Adrian McLachlan, Andrew Parson, Amr Zeineldine and Hany Wahba.

Employment and Remuneration Committee

The Employment and Remuneration Committee meets to consider the employment packages for those employees of the cluster whose remuneration fall outside the scope of Agenda for Change.
Chair: Caroline Hewitt
Lead Executive Member: Una Dalton, Director of Human Resources
Non-Executive Members: Sue Gallagher, Graham Laylee, Richard Gibbs, Robert Park, Rona Nicholson, David Whiting, Keith Wood, Paul Cutler, Harvey Guntrip, James Gunner, Susan Free and Jeremy Fraser

6.2 Governance Statement

The PCT's Annual Governance statement is a separate document included as part of Annual Accounts reporting framework and is available on request.

7. REMUNERATION REPORT

7.1 *Unaudited*

The Employment and Remuneration committee of Cluster PCT's meets to consider the employment arrangements for those employees across NHS South East London whose remuneration falls outside the scope of agenda for Change.

The following information relates to the employment of Cluster executive directors and non-executive directors and Chair, Managing Director and Director of Public Health for the PCT.

7.2 Contract details

As a consequence of implementing Health and Social Care Act 2012, all the PCTs and SHAs were abolished on 31st March 2013. Contractual arrangements for officer Board members and Non-executive members, therefore, also terminate on the same date.

Name	Title	Start Date	End Date
Andrew Kenworthy (to 4/9/2012) *	Chief Executive, NHS SEL Cluster	03/10/2011	31/03/2013

Christina Craig *	Interim Chief Executive, NHS SEL Cluster	03/09/2012	31/03/2013
Gill Galliano	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	01/04/2011	30/06/2012
Richard Chapman *	Director of Finance, NHS SEL Cluster	01/112011	31/03/2013
Alison Tonge *	Interim Director of Finance, NHS SEL Cluster	06/08/2012	15/11/2012
Malcolm Dennett *	Interim Director of Finance, NHS SEL Cluster	14/11/2012	31/03/2013
Jane Schofield	Director of Operations, NHS SEL Cluster	01/04/2011	31/03/2013
Donna Kinnair	Director of Nursing, NHS SEL Cluster	01/04/2011	01/10/2012
Jane Clegg	Director of Nursing, NHS SEL Cluster	09/11/2012	31/03/2013
Caroline Hewitt	Chair, NHS SEL Cluster	01/04/2007	31/03/2013
Steven Corbishley	Non Executive Director, NHS SEL Cluster	14/04/2011	31/03/2013
Susan Gallagher	Non Executive Director, NHS SEL Cluster	01/04/2007	31/03/2013
Richard Gibbs	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Graham Laylee	Non Executive Director, NHS SEL Cluster	16/07/2007	15/07/2013
Rona Nicholson	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Robert Park	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
David Whiting	Non Executive Director, NHS SEL Cluster	01/04/2011	31/03/2013
Dr Adrian McLachlan	Local Clinical Commissioning Committee Chair	01/04/2011	31/03/2013
Andrew Eyres	Managing Director	01/04/2002	31/03/2013

Dr Ruth Wallis	Director of Public Health	01/05/2002	31/03/2013

* During 2012-13 both the Accountable Officer and the Statutory Director of Finance moved to new roles within the NHS. However, for the purposes of these statutory roles they continued to assume this accountability through to the 31 March 2013 and they attended both Joint Boards and Audit Committees. To recognise the requirement for leadership, as a result of these moves, an interim Chief Executive was appointed through to the 31 March and an Interim Finance Director. The Interim Finance Director appointment changed during the course of the year.

7.3 Senior Management cost sharing arrangements

The PCT senior management comprises cluster posts of Chair, Chief Executive and Directors of Finance, Corporate Development, Operations and Nursing shared equally across the five PCTs and the Care Trust in the Cluster. The Non-Executive directors appointed to the Cluster Board are shared equally across their representation of separate health economies of LSL (Lambeth, Southwark and Lewisham PCTs) and BBG (Bexley Care Trust, Bromley and Greenwich PCTs). The rest of the PCT Board consists of local Managing Director, Director of Public Health and GP lead Chair of the PCT's Clinical Commissioning Committee.

7.4 The costs of the Executive and Non-Executive members reported below are the PCT's share of costs, where relevant, in the line with the arrangements described above.

Audited

Cluster Board Executive and Non-Executive members (*PCT's share of costs*)

Salaries and allowances

		2012/13				2011/12			
Name	**Title**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind (rounded to the nearest £00)**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Bonus Payments (bands of £5,000)**	**Benefits in kind (rounded to the nearest £00)**
Andrew Kenworthy (to 4/9/2012)	Chief Executive, NHS SEL Cluster	5-10				10-15			
Simon Robbins (to 31/08/2011)	Chief Executive, NHS SSEL Cluster					10-15			
Christina Craig (from 3/9/2012)	Interim Chief Executive, NHS SEL	25-30							
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	5-10				20-25			
Richard Chapman	Director of Finance, NHS SEL Cluster	15-20				10-15			
Alison Tonge (from 6/8/2012 to 15/11/2012)	Interim Director of Finance, NHS SEL	10-15							
Malcolm Dennett (from 14/11/2012)	Interim Director of Finance, NHS SEL Cluster	10-15							
Jane Schofield	Director of Operations, NHS SEL Cluster	20-25	40-45			20-25			
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	15-20	15-20			10-15			
Jane Clegg (from 9/11/2012)	Director of Nursing, NHS SEL Cluster	5-10							
Caroline Hewitt	Chair, NHS SEL Cluster	5-10				5-10			
Steven Corbishley (No remuneration paid)	Non Executive Director, NHS SEL	0				0			
Susan Gallagher	Non Executive Director, NHS SEL	1-5				1-5			
Richard Gibbs	Non Executive Director, NHS SEL	1-5				1-5			
Graham Laylee	Non Executive Director, NHS SEL	1-5				1-5			
Rona Nicholson (No remuneration paid)	Non Executive Director, NHS SEL	0				0			
Robert Park	Non Executive Director, NHS SEL	1-5				1-5			
David Whiting	Non Executive Director, NHS SEL Cluster	1-5				1-5			

Lambeth PCT senior staff – these staff represent Lambeth PCT on Cluster Board.
Salaries and allowances

		2012/13				2011/12			
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Benefits in kind (rounded to the nearest £00)
Dr Adrian McLachlan	Local Clinical Commissioning Committee Chair	55-60				55-60			
Andrew Eyres	Managing Director	105-110				110-115			
Dr Ruth Wallis	Director of Public Health	120-125		20-25		125-130		20-25	

Pension Benefits (*PCT's share of Pension entitlement costs*)

Non-Executive directors on the Board and General Practitioners on Clinical Commissioning Collaborative Committee are not employed by the PCT and are not members of the NHS pension scheme. Their pension benefits are, therefore, not required to be reported in the remuneration report.

In line with the guidance in the Manual of Accounts, it is not possible to apportion the cash equivalent transfer value (CETV) across the PCTs and Care Trust in the Cluster on any systematic basis. This has been, therefore, reported below in full.

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2013	Lump Sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
Andrew Kenworthy	Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	5-10	25-30	896	829	24	
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	5-10	20-25	N/A	867	N/A	
Richard Chapman	Director of Finance, NHS SEL Cluster	0-2.5	2.5-5	2.5-5	10-15	287	192	85	
Jane Schofield (Left Pension scheme 2011-12 restated)	Director of Operations, NHS SEL Cluster	0-2.5	0-2.5	5-10	25-30	1157	1157	0	
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	0-2.5	2.5-5	5-10	10-15	565	475	65	
Andrew Eyres	Managing Director	0-2.5	0-2.5	35-40	105-110	623	585	8	
Dr Ruth Wallis	Director of Public Health	0-2.5	0-2.5	55-60	165-170	1128	1060	13	

7.5 The costs of Cluster Board executive and Non-Executive members, reported below are the total remuneration and pension entitlement of the individual. These costs are shared across the six PCTs and Care Trust in South East London.

Cluster Board Executive and Non-Executive members *(Total remuneration)*

Salaries and allowances

Name	Title	2012/13 Salary (bands of £5,000	2012/13 Other Remuneration (bands of £5,000)	2012/13 Bonus Payments (bands of £5,000)	2012/13 Benefits in kind (rounded to the nearest £00)	2011/12 Salary (bands of £5,000	2011/12 Other Remuneration (bands of £5,000)	2011/12 Bonus Payments (bands of £5,000)	2011/12 Benefits in kind (rounded to the nearest £00)
		£000	£000	£000	£00	£000	£000	£000	£00
Andrew Kenworthy (to 4.9.2012)	Chief Executive, NHS SEL Cluster	45-50				85-90			
Simon Robbins (to 31/08/2011)	Chief Executive, NHS SSEL Cluster					60-65			
Christina Craig (from 3.9.2012)	Interim Chief Executive, NHS SEL Cluster	150-155							
Gill Galliano (to 30.6.2012)	Director of Development, NHS SEL Cluster	30-35				125-130			
Jane Schofield	Director of Operations, NHS SEL Cluster	130-135	260-265			130-135			
Richard Chapman	Director of Finance, NHS SEL Cluster	110-115				65-70			
Alison Tonge (from 6.8.12 to 15.11.2012)	Interim Director of Finance, NHS SEL Cluster	80-85							
Malcolm Dennett (from 14.11.2012)	Interim Director of Finance, NHS SEL Cluster	70-75							
Donna Kinnair (to 1.10.2012)	Director of Nursing, NHS SEL Cluster	95-100	105-110			95-100			
Jane Clegg (from 9.11.2012)	Director of Nursing, NHS SEL Cluster	50-55							
Caroline Hewitt	Chair, NHS SEL Cluster	40-45				40-45			
Steven Corbishley	Non Executive Director, NHS SEL Cluster	Nil Remuneration				Nil Remuneration			
Susan Gallagher	Non Executive Director, NHS SEL Cluster	10-15				10-15			
Richard Gibbs	Non Executive Director, NHS SEL Cluster	10-15				10-15			
Graham Laylee	Non Executive Director, NHS SEL Cluster	10-15				10-15			
Rona Nicholson	Non Executive Director, NHS SEL Cluster	Nil Remuneration				Nil Remuneration			
Robert Park	Non Executive Director, NHS SEL Cluster	5-10				5-10			
David Whiting	Non Executive Director, NHS SEL Cluster	10-15				10-15			

Lambeth PCT senior staff – these staff represent Lambeth PCT on Cluster Board.

Salaries and allowances

		2012/13 Salary (bands of £5,000)	2012/13 Other Remuneration (bands of £5,000)	2012/13 Bonus Payments (bands of £5,000)	2012/13 Benefits in kind (rounded to the nearest £00)	2011/12 Salary (bands of £5,000)	2011/12 Other Remuneration (bands of £5,000)	2011/12 Bonus Payments (bands of £5,000)	2011/12 Benefits in kind (rounded to the nearest £00)
Dr Adrian McLachlan	Local Clinical Commissioning Committee Chair	55-60				55-60			
Andrew Eyres	Managing Director	105-110				110-115			
Dr Ruth Wallis	Director of Public Health	120-125		20-25		125-130		20-25	

Pension Benefits *(Total Pensions entitlement)*

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2013	Lump Sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in Cash Equivalent Transfer Value	Employer contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
Andrew Kenworthy	Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	50-55	155-160	896	829	24	
Gill Galliano (to 30/6/2012)	Director of Development and Joint Deputy Chief Executive, NHS SEL Cluster	0-2.5	0-2.5	45-50	145-150	N/A	867	N/A	
Richard Chapman	Director of Finance, NHS SEL Cluster	5-7.5	17.5-20	20-25	60-65	287	192	85	
Jane Schofield (Left Pension scheme 2011-12 restated)	Director of Operations, NHS SEL Cluster	0-2.5	0-2.5	55-60	165-170	1157	1157	0	
Donna Kinnair (to 1/10/2012)	Director of Nursing, NHS SEL Cluster	0-2.5	2.5-5	25-30	85-90	565	475	65	
Andrew Eyres	Managing Director	0-2.5	0-2.5	35-40	105-110	623	585	8	
Dr Ruth Wallis	Director of Public Health	0-2.5	0-2.5	55-60	165-170	1128	1060	13	

7.6 Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, ***contributions paid by the employee*** (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

7.7 Pay Multiples – *(Unaudited)*

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Lambeth PCT in the financial year 2012-13 was £147,500 (2011-12, £125,805). This was 3.18 times (2011-12 2.79 times) the median remuneration of the workforce, which was £46,374 (2011-12 £45,068)
In 2012-13, no (2011-12, 1) employee received remuneration in excess of the highest paid director.

Remuneration ranged from £3,906 to £149,462 (2011-12 £5,517 to £149,462).
Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind excluding severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The slight increase in the multiple between 2011-12 and 2012-13 is due to the change in the salary of the highest paid director from £125,805 to £149,462 as well as the increase in the median salary from £45,068 to £46,374.

7.8 Exit Packages

The PCT agreed two exit package during the year. The table provided below is also reported in the PCT's published accounts and is being reproduced here for completeness.

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	**0**	**0**	**0**	0	0	**0**
£10,001-£25,000	**0**	**0**	**0**	0	0	**0**
£25,001-£50,000	**1**	**0**	**1**	0	0	**0**
£50,001-£100,000	**0**	**0**	**0**	0	1	**1**
£100,001 - £150,000	**0**	**0**	**0**	0	0	**0**
£150,001 - £200,000	**0**	**0**	**0**	0	0	**0**
>£200,000	**1**	**0**	**1**	0	0	**0**
Total number of exit packages by type (total cost	**2**	**0**	**2**	**0**	**1**	**1**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	289,480	0	**289,480**	0	100,000	**100,000**

7.9 Off Payroll Engagements – *(unaudited)*

Table 1: For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012	Lambeth PCT
	No.
No. in place on 31 January 2012	**45**
of which	
No that have since come onto the organisation's payroll	0
of which	
No. that have since been re-negotiated/re-engaged, to include contractual clauses allowing the department to seek assurance as to their tax obligations	0
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the department to seek assurance as to their tax obligations	17
No. that have come to an end (**31st March 2013**)	28
Total	**45**

Table 2: For all off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months.	
No. of new engagements	49
of which	
No of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance Obligations	49
of which	
No. for whom assurance has been requested and received	26
No. for whom assurance has been requested but not received (See Below)	0
No. that have been terminated as a result of assurance not being received	0
No. for whom assurance was not required due to	
Left the organisation	12
Joined an agency	6
Enetered substantive employment	4
Request not made	1

7.10 Related Party Transactions

Lambeth Primary Care Trust is a body corporate established by order of the Secretary of State for Health.

During the year the following Board Members and members of Clinical Commissioning Collaborative Committee and parties related to them have undertaken material transactions with Lambeth Primary Care Trust as follows:

	Services Received from Organisation	Payments to Related Party
		£
John Balazs - Binfield General Practice	Primary Care	1,003,300
John Balazs - Mawbey Brough Practice	Primary Care	1,204,182
Patricia Kirkman - Tulse Hill Practice	Primary Care	1,050,813
Adrian McLachlan - Heatherington Group Practice	Primary Care	1,574,002
Adrian McLachlan - Pavillion Medical Centre	Primary Care	712,494
Gillian Ellsbury - Paxton Green Group Practice	Primary Care	2,555,536
Redmond Walsh - Clapham Family Practice	Primary Care	2,670,132
Rajive Mitre - Lambeth Walk Group Practice	Primary Care	1,118,040

There were no material amounts due to or outstanding from the above related parties.

The Department of Health, as Lambeth PCT's parent department, is regarded as a related party. During the year 2012/13, Lambeth Primary Care Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below;

		Payments to Related Party
		£000
Guy's and St Thomas NHS Foundation Trust	Acute and Community healthcare	198,013
Kings Healthcare NHS Foundation Trust	Acute and Community healthcare	101,114
South London and Maudsley NHS Foundation Trust	Mental healthcare services	88,011
Croydon PCT	Specialist Services	56,708
St Georges Healthcare NHS Trust	Acute Healthcare Services	25,531
London Ambulance Services NHS Trust	Emergency Services	10,899
Southwark PCT	Commissioning of Healthcare	6,168
Lewisham PCT	Commissioning of Healthcare	1,785
London Borough of Lambeth	Learning disability and community healthcare services	2,711

		Income from Related Party
		£000
Guy's and St Thomas NHS Foundation Trust	ICT and Site Service charges	8,430

8. HOW WE SPENT YOUR MONEY

LAMBETH PCT SUMMARY FINANCIAL STATEMENTS 2012/13

These summary financial statements are a summary of the information in the PCT's full annual accounts for 2012/13. The summary financial statements might not contain sufficient information for a full understanding of the PCT's financial position and performance.

IFRSs are accounting standards issued by the International Accounting Standards Board (IASB). The term IFRS refers to the international equivalent to UK GAAP, the set of Generally Accepted Accounting Principles that includes accounting standards, interpretations, the IASB's framework and established accounting practice. The Chancellor's 2007 Budget announced that the accounts of central government departments and entities in the wider public sector will be produced using IFRS, as interpreted for the public sector in the IFRS-based Financial Reporting Manual (FReM). Central government, NHS Trusts, Primary Care Trusts and NHS Foundation Trusts all need to adopt IFRS and the annual accounts for government organisations and the NHS are to be prepared using IFRS standards.

Financial balance

PCTs have a statutory duty to keep expenditure within the resource limits set by the Department of Health for revenue and capital separately. The PCT's audited annual accounts show a surplus of £7.093M on revenue and £305K on capital.

	2012/13 Revenue £000	**2012/13 Capital £000**	**2012/13 Total £000**
Resource Limit	712,269	24,955	737,224
Net Operating Costs	705,176	24,650	729,826
Surplus / (Deficit)	**7,093**	**305**	**7,398**

All the Primary Care Trusts and Strategic Health Authorities were abolished from 1 April 2013. Under Department of Health year-end carry forward arrangements and guidance around financial planning for 2013/14, Lambeth CCG has been advised by DH to assume £4.6m, being proportionate to its share of CCG allocation as a carry forward resource in 2013/14 plans. Underspends against Capital Resource Limits are not carried forward. PCTs bid for capital resources on an annual basis.

Cash performance

The PCT has a statutory duty to remain within its set cash limit. There is a single cash limit covering both revenue and capital. The PCT under drew its 2012/13 Cash Limit by £9m in line with forecasts provided to NHS London. The Department of Health also sets a maximum year-end cash balance for PCTs of £250k. The PCT's cash balance as at 31st March 2013 was £26k.

	£000
Opening Cash balance 1 April 2012	19
Cash drawings including cash top sliced by DH	705,625
Cash Outgoings	(696,617)
Cash returned to DH	(9,001)
Closing cash balance 31 March 2013	**26**

Capital charges

Capital charges were introduced in the NHS in 1991 to increase awareness of the cost of owning assets. The amount payable is based on the actual opening and closing Balance Sheets for the year. There are two elements to this: depreciation of fixed assets and a charge of 3.5 per cent on net relevant assets. The Department of Health has revised the mechanism for charging capital charges interest since 2011/12. The PCT revenue resources for 2012/13 were adjusted by £2k for capital charges interest. Capital charges for Lambeth PCT for 2012/13 were as follows:

	£000
Depreciation	1,804
3.5% cost of capital charge on net relevant assets	(2)
Total	**1,802**

Public sector payment targets

In addition to the PCT's statutory targets, the Department of Health requires that NHS bodies pay their creditors in accordance with the Prompt Payment Code (PPC) and government accounting rules. The target is to pay 95 per cent of all creditors within 30 days of receipt of the goods or a valid invoice (whichever is later) unless other payment terms have been agreed with the supplier. Lambeth PCT is an approved signatory to the Prompt Payment Code. The PCT's performance against this target is reported below:

Non-NHS creditors	**2012/13 Number**	**2012/13 £000**	**2011/12 Number**	**2011/12 £000**	**2010/11 Number**	**2010/11 £000**
Total bills paid in the year	15,095	84,822	11,175	63,713	23,280	131,827
Total bills paid within target	13,922	79,672	10,364	60,058	19,321	118,578
Percentage of bills paid within target	**92%**	**94%**	**93%**	**94%**	**83%**	**90%**

NHS creditors	**2012/13 Number**	**2012/13 £000**	**2011/12 Number**	**2011/12 £000**	**2010/11 Number**	**2010/11 £000**

Total bills paid in the year	**4,631**	**578,428**	**4,436**	**529,520**	**4,162**	**557,120**
Total bills paid within target	**4,392**	**556,123**	**4,142**	**503,556**	**3,690**	**546,358**
Percentage of bills paid within target	**95%**	**96%**	**93%**	**95%**	**89%**	**98%**

Comparisons of 2012/13 annual accounts with previous years

1 Net operating costs:

The overall growth in net operating costs of £35m (4.9%) since 2011/12 reflects the funding growth received by the PCT during 2012/13.

	2006/07	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**Change from 2011/12**	
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	%
Gross Operating Costs	503	545	593	666	689	718	753	35	4.9%
Including income of	22	27	32	31	28	38	50	12	31.6%
Net Operating Costs	**481**	**518**	**561**	**635**	**661**	**680**	**705**	**25**	**3.7%**

2 Non-Current Assets

Lambeth PCT's land and buildings have been revalued by the District Valuer as at 31 March 2013 by carrying out a full valuation exercise. This resulted in a net decrease in asset values of £5.5m. During the year the PCT incurred capital spend of £24.691m. The PCT incepted in its books the LIFT asset land and building for Akerman Health centre valued at 31 March 2013 at £15.35m. The net increase in non current assets of £17.6m reflects these transactions as well as the depreciation charges of £1.8M.

Property, plant and equipment was as follows:

2006/07 £m	Restated 2007/08 £m	Restated 2008/09 £m	2009/10 £m	2010/11 £m	Restated 2011/12 £m	2012/13 £m	Change £m
37.6	52.1	51.6	49.0	51.4	54.5	72.1	17.6

3 Net Current Liabilities

	2006/07 £m	Restated 2007/08 £m	Restated 2008/09 £m	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	Change £m
Current Assets	14.3	17.3	12.6	9.6	8.0	11.4	8.4	(3)
Current Liabilities	(33.7)	(37.2)	(30.7)	(37.2)	(32.0)	(41.1)	(44.5)	3
Net Current Liabilities	**(19.4)**	**(19.9)**	**(18.1)**	**(27.6)**	**(24.0)**	**(29.7)**	**(36.1)**	**0**

4 Taxpayers' Equity

	2009/10 £m	2010/11 £m	2011/12 * £m	2012/13 £m	Change £m
General Fund - deficit	(10.8)	(4.4)	(2.9)	(11.4)	(8.5)
Revaluation Reserve	12.9	12.7	11.3	10.6	(0.7)
Donated Asset Reserve	3.9				
Total	**6.0**	**8.3**	**8.4**	**0.8**	**(9.2)**

*2010/11 has not been restated for the effect of a change in accounting policy made in 2011/12 for donated assets or 2009/10 and 2010/11 for a restatement made in 2012/13 for leased land.

5 Pensions

Past and present employees are covered by the provisions of the NHS Pensions Scheme. For full details of how pension liabilities are treated please see Note 7.4 Accounting Policies in the Annual Accounts. For details of senior manager's pension entitlements please see the PCT's remuneration report.

NHS Lambeth

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	**(703,154)**	(679,058)
Depreciation and Amortisation	**1,804**	1,429
Impairments and Reversals	**4,538**	616
Other Gains / (Losses) on foreign exchange	**0**	0
Donated Assets received credited to revenue but non-cash	**0**	0
Government Granted Assets received credited to revenue but non-cash	**0**	0
Interest Paid	**(2,149)**	(1,420)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**0**	0
(Increase)/Decrease in Trade and Other Receivables	**3,574**	(3,392)
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**1,341**	7,634
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(16)**	(1,572)
Increase/(Decrease) in Provisions	**3,842**	510
Net Cash Inflow/(Outflow) from Operating Activities	**(690,220)**	**(675,253)**
Cash flows from investing activities		
Interest Received	**127**	9
(Payments) for Property, Plant and Equipment	**(6,035)**	(1,611)
(Payments) for Intangible Assets	**0**	0
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**41**	230
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**0**	0
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(5,867)**	**(1,372)**
Net cash inflow/(outflow) before financing	**(696,087)**	**(676,625)**
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(530)**	0
Net Parliamentary Funding	**696,624**	677,810
Capital Receipts Surrendered	**0**	0
Capital grants and other capital receipts	**0**	0
Cash Transferred (to)/from Other NHS Bodies (free text note required)	**0**	(1,166)
Net Cash Inflow/(Outflow) from Financing Activities	**696,094**	**676,644**
Net increase/(decrease) in cash and cash equivalents	**7**	**19**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**19**	**0**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**26**	**19**

NHS Lambeth

Statement of Financial Position at 31 March 2013

	31 March 2013	31 March 2012
	£000	£000
Non-current assets:		
Property, plant and equipment	**72,073**	54,472
Intangible assets	**0**	0
investment property	**0**	0
Other financial assets	**719**	719
Trade and other receivables	**0**	0
Total non-current assets	**72,792**	55,191
Current assets:		
Inventories	**0**	0
Trade and other receivables	**8,093**	11,355
Other financial assets	**0**	0
Other current assets	**0**	0
Cash and cash equivalents	**26**	19
Total current assets	**8,119**	11,374
Non-current assets held for sale	**0**	0
Total current assets	**8,119**	11,374
Total assets	**80,911**	66,565
Current liabilities		
Trade and other payables	**(40,403)**	(39,478)
Other liabilities	**0**	0
Provisions	**(3,443)**	(1,556)
Borrowings	**(356)**	(53)
Other financial liabilities	**0**	0
Total current liabilities	**(44,202)**	(41,087)
Non-current assets plus/less net current assets/liabilities	**36,709**	25,478
Non-current liabilities		
Trade and other payables	0	0
Other Liabilities	0	0
Provisions	(1,939)	0
Borrowings	(35,588)	(17,037)
Other financial liabilities	0	0
Total non-current liabilities	**(37,527)**	(17,037)
Total Assets Employed:	**(818)**	8,441
Financed by taxpayers' equity:		
General fund	(11,379)	(2,827)
Revaluation reserve	10,561	11,268
Other reserves	0	0
Total taxpayers' equity:	**(818)**	8,441

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	**27,164**	21,588
Other costs	**725,513**	695,903
Income	**(49,523)**	(38,433)
Net operating costs before interest	**703,154**	679,058
Investment income	**(127)**	(9)
Other (Gains)/Losses	**0**	(19)
Finance costs	**2,149**	1,420
Net operating costs for the financial year	**705,176**	680,450
Transfers by absorption -(gains)	**0**	
Transfers by absorption - losses	**0**	
Net (gain)/loss on transfers by absorption	**0**	
Net Operating Costs for the Financial Year including absorption transfers	**705,176**	**680,450**
Of which:		
Administration Costs		
Gross employee benefits	**23,173**	18,050
Other costs	**25,810**	14,168
Income	**(25,356)**	(20,013)
Net administration costs before interest	**23,627**	**12,205**
Investment income	**0**	0
Other (Gains)/Losses	**0**	0
Finance costs	**0**	0
Net administration costs for the financial year	**23,627**	**12,205**
Programme Expenditure		
Gross employee benefits	**3,991**	3,538
Other costs	**699,703**	681,735
Income	**(24,167)**	(18,420)
Net programme expenditure before interest	**679,527**	**666,853**
Investment income	**(127)**	(9)
Other (Gains)/Losses	**0**	(19)
Finance costs	**2,149**	1,420
Net programme expenditure for the financial year	**681,549**	**668,245**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,245**	1,393
Net (gain) on revaluation of property, plant & equipment	**(538)**	0
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year*	**705,883**	**681,843**

10 POST BALANCE SHEET EVENTS

As disclosed within note 1 due to the Health and Social Care Bill as of 1st April 2013 the PCT in its current legal form will be abolished. As a result the PCT's functions will continue with either a Commissioning Support Unit (CSU), Clinical Commissioning Group (CCG), NHS England, NHS Foundation Trusts (FT) or Local Authorities (LA). Estates functions will be transferred to NHS Property Services Limited (NHS PS). Ultimate control will still reside with the Department of Health.

All assets and liabilites contained within the statement of financial position as at 31st March 2013 must be identified and agreed for transfer.

Under this NHS Transition, the PCT's assets and liabilities will be split between different 'Receivers' and, in some cases, multiple 'Receivers' will require access to an asset or be assigned a liability. The principles for the split of residual balances is still subject to Department of Health guidance.

The majority of assets and liabilities (including all land and buildings) will transfer by way of a 'Sender' organisation's Transfer Schemes. A Transfer Scheme is an instrument in writing made by the Secretary of State under sections 300 to 302 of the Act. It can deal with the transfers of staff, property and liabilities between those entities as specified in Schedules 22 and 23 to the Act but unlike Transfer Orders does not need to be laid before Parliament.

Where functions transfer, any claim, liability and financial asset, which relate to that will follow. However NHS England will take historical NHS Litigation Authority (NHSLA) indemnified clinical negligence claims, including those incurred but not reported relating to new functions of CCG's or Local Authorities.

The final year-end aggregate surplus generated by the PCTs in 2012/13 will be carried forward to NHS England in 2013/14. CCGs will not inherit legacy debt, but balances will transfer from PCTs, in line with provisions of the Act, based on the principles set out below subject to further guidance from the Department of health on the split of financial balances and related financial transactions.

- Liabilities that correspond to an asset which relate to a particular function should transfer with that asset from a sender to a receiver by reference to the destination of the function.

- Liabilities that correspond to a function or policy that is being moved from a sender should transfer to the nominated receiver for that function.

- Discrete, and current assets and liabilities, even if associated with a function continuing in 2013/14 will transfer to the Department of Health.

- Liabilities relating to the PCT as a statutory body in its own right that do not relate to an ongoing function such as VAT or tax liabilities, will transfer to the Department of Health.

- Employer liabilities will transfer to the new employer, where an individual's employment is transferred to a receiver organisation.

- Where employment of staff ceases prior to 1st April 2013, the employer liabilities related to those staff members will transfer to Department of Health.

11 Running costs

PCTs are required to report the proportion of their costs per head of local weighted population that is spent on management. The Department of Health (DH) has issued guidance on the definition of running costs.

	2012/13	2011/12	Change
Running costs (£000s)	10,559	11,930	1,371
Weighted population (number)	351,815	351,815	-
Management cost per head of weighted population (£)	**30**	**34**	**11.8 %**

The PCT measures its running costs according to the definitions provided by the Department of Health.

The PCT running costs for 2012/13 have been reduced by £1.371m (11.8%) in the year.

Audit

The PCT's external auditor is Deloitte LLP. During the financial year 2012/13 £122k (including VAT) was paid in respect of carrying out the external audit of the PCT in accordance with the Code of Audit Practice.

2012/13 Accounts Certificate of Financial Assurance to the Department of Health Director General, Strategy Finance and NHS

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Lambeth Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that in my role managing the preparation of the annual statutory accounts, the accounts were prepared in the format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year. As required the accounts:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

Richard Chapman
Director of Finance SEL Cluster 2012/13

Signature: 

Date: 24 April 2013

2012/13 Accounts Certificate of Assurance to the Department of Health Director General, Strategy Finance and NHS

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Lambeth Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the PCT:

- had in place effective management systems to safeguard public funds and assets and assist in the implementation of corporate governance;
- kept proper accounting records which disclosed with reasonable accuracy at any time the financial position of the PCT;
- took reasonable steps for the prevention and detection of fraud and other irregularities;
- achieved value for money from the resources available to the PCT;
- applied income and expenditure to the purposes intended by Parliament and conformed to the authorities which governed them; and
- had effective and sound financial management systems in place.

I also confirm that in my role overseeing the preparation of the annual statutory accounts, the accounts were prepared in the format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year. As required the accounts;

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

Name: Andrew Kenworthy

Signature:

Date: 24 April 2013

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE PRIMARY CARE TRUST 2012-13 ACCOUNTS

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts of Lambeth Primary Care Trust to discharge the following responsibilities for the Department of Health:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the primary care trust;

- the expenditure and income of the primary care trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, and from the assurances provided by the PCT Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

Signed.....

Date 31 May 2013

Carl Vincent
Director of Provider Finance and Finance Transition

INDEPENDENT AUDITOR'S REPORT TO THE ACCOUNTABLE OFFICER OF LAMBETH PCT

We have examined the summary financial statements for the year ended 31 March 2013 which comprises the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement, and the notes on Financial Balance, Post Balance Sheet Events, Running Costs and Audit.

This report is made solely to the Accountable Officer for Lambeth Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. Our audit work has been undertaken so that we might state to the Primary Care Trust those matters we are required to state to them in auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Primary Care Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditor

The Signing Officer is responsible for preparing the Annual Report.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statement.

We conducted our work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our opinion on those financial statements.

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of the Lambeth Primary Care Trust for the year ended 31 March 2013.

Matthew Hall (Engagement Lead)
for and on behalf of Deloitte LLP

Appointed Auditor

St Albans, United Kingdom

The Annual Report including the remuneration report was approved by the DH authorised signatory at the DH sub Audit Committee for South East London on 31 May 2013.

Carl Vincent
Director of Provider Finance and Finance Transition

Further Information

A copy of the 2012/13 audited annual accounts as well as the PCT's Annual Governance Statement is available from:

Christine Caton
Chief Financial Officer
Lambeth CCG
1 Lower Marsh, London SE1 7NT
Tel 020 3049 4133
christine.caton@nhs.net

Department of Health

NHS

Lambeth Primary Care Trust

2012-13 Accounts

Published to gov.uk, in PDF format only.

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Lambeth Primary Care Trust

2012-13 Accounts

Lambeth PCT

Annual Accounts

Year Ended 31st March 2013

FOREWORD TO THE ACCOUNTS

LAMBETH PRIMARY CARE TRUST

These accounts for the year ended 31st March 2013 have been prepared by the LambethPrimary Care Trust under section 98(2) of the National Health Service Act 1977 in the form which the Secretary of State has, with the approval of the Treasury, directed.

1 Introduction

Lambeth Primary Care Trust (PCT) was established in April 2002 (Statutory Instrument 2002 No.999). The PCT was responsible for improving health; for commissioning primary, community, hospital and other health services for the population registered with GP practices within the London Borough of Lambeth.

The PCT took on the responsibilities of the former Community Health South London NHS Trust and the former Lambeth,

Southwark and Lewisham Health Authority, including the two North and South Lambeth Primary Care Groups, from April 2002. Lambeth PCT, along with every other PCT in England ceased to exist on 31st March 2013. From the 1st April 2013, as a result of the implementation of the Health and Social Care Act 2012, commissioning for health services and health improvement in Lambeth became the responsibilty of NHS Lambeth Clinical Commissioning Group (CCG), the NHS Commissioning Board and the London Borough of Lambeth

Mission and Vision and Values

During 2012/13 Lambeth Clinical Commissioners reviewed the Mission and Vision for commissioners in Lambeth, as follows:

Our Mission is to improve the health and reduce health inequalities of Lambeth people and to commission the highest quality health services on their behalf.

The Vision was to focus on four core commitments:

1.Health improvement is at the heart of all we do. We will increase life expectancy for all and reduce the difference in life expectancy between the most and
2.We will maintain a thriving, financially viable, health economy delivering safe and effective high quality care.
3.We will commission comprehensive integrated care that meets the needs of local people. We will value diversity amongst providers, but will expect excellent
4.In delivering this Vision we recognise the need:

- for a rigorous population needs based approach to commissioning, supported by public health expertise.
- to work with Lambeth people and their representatives to commission services that best meet their needs.
- to work in partnership with colleagues, across geographic, organisational and professional boundaries. This will include primary care care practitioners, the London Borough of Lambeth, King's Health Partners and neighbouring health commissioners
- to support innovation in workforce development and in the local application of teaching, training and research.
- to look first to local colleagues for management support.

The Lambeth Clinical Commissioning Collaborative Board (LCCCB) has also agreed a set of values

- **We always tell the truth**
- **We are fair**
- **We are open**
- **We recognise our responsibilities to service users and the wider public**
- **We act responsibly as a public sector organisation**

Until April 2011 the PCT also provided community health services for Lambeth patients including community nursing, health visiting, school nursing, child and adult therapy services, specialist child health services, foot health services, podiatric surgery, elderly and intermediate care services, rapid response service, sickle cell services, reproductive and sexual health services, specialist support to refugees and asylum seekers, community tuberculosis team and drug and alcohol healthcare services.

From 1st April 2011 the PCT along with Southwark PCT, transferred its community health services to Guy's and St Thomas' NHS Foundation Trust, on behalf of Kings' Health Partners.

In 2012/13, the PCT employed 376 staff, of which 271 are permanently employed (average staff numbers). Lambeth PCT hosts the cluster arrangements on behalf of South East London PCTs and Care Trust and from 1st October 2012 the South London Commissioning Support Unit. The total staff employed by Lambeth PCT includes staff employed as host organisation.

The PCT has an established record of working with the NHS and other partners to achieve delivery of its objectives and secure value for money.

Within Lambeth there are 49 GP Practices, with 268 GPs, 64 pharmacies, 36 NHS dental practices and 21 ophthalmic practices.

Acute hospital services are commissioned mainly from Guy's & St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust and St George's Healthcare NHS Trust. Mental health services are commissioned mainly from South London and Maudsley NHS Foundation Trust, in conjunction with the London Borough of Lambeth. The PCT is represented on the Members Councils of all three local Foundation Trusts by PCT Board members. Guy's and St Thomas' NHS Foundation Trust became an NHS Foundation Trust in July 2004, South London & Maudsley NHS Foundation Trust in November 2006 and Kings Healthcare NHS Foundation Trust in December 2006. Along with King's College London, the three local Foundation Trusts have worked in partnership to establish an Academic Health Sciences Centre, King's Health Partners, receiving Department of Health accreditation in March 2009.

From April 2002 to March 2006 certain support services were provided to the PCT by the South East London Shared Services Partnership, hosted by Lewisham PCT. These services included ICT, estates and facilities support, patient transport, training and development, recruitment and financial services. From 1st April 2006 new arrangements for the management of these services applied and the PCT hosted the management of facilities management services. Southwark PCT hosted ICT services and Lewisham PCT workforce and primary care support services. Facilities Management services transferred to Guy's and St Thomas' NHS Foundation Trust on 1st April 2011 along with Community Services. The PCT migrated its financial support services to the national NHS Shared Business Services (SBS) from 1st December 2006. SBS is a 50:50 owned joint venture between the NHS and a private sector organisation (Xansa) providing financial and accounting services to the NHS since 2005. SBS works with over 40% of NHS organisations.

During 2008/09 Lambeth PCT hosted the London-wide Specialist Commissioning Group, with this function transferring to Croydon PCT from 1st April 2009. Lambeth PCT along with Lewisham and Southwark PCTs established the Lambeth, Southwark and Lewisham Acute Commissioning Alliance from 1st April 2009, hosted by Lambeth PCT. This was overseen by a Joint Committee of the three PCTs. In addition, Lambeth PCT worked with Southwark, Lewisham, Bromley, Bexley and Greenwich PCTs to establish the South East London Sector Commissioning Vehicle, hosted by Greenwich PCT from 1st April 2009 and Lambeth PCT from 1 April 2010, overseen by a Joint Committee of the six PCTs.

Over 2010/11 the PCT worked with the six PCTs across South East London (Lambeth, Southwark, Lewisham, Bromley, Bexley and Greenwich) to further develop collective arrangements to achieve improved value for money and to ensure ongoing delivery, to deliver the organisational change needed to deliver management cost savings requirements. A new NHS South East London Cluster arrangement was established from 1st April 2011 whereby, within individual PCT statutory arrangements, a range of roles and functions are delivered across the six PCTs. This was in line with national transition guidance following the publication of the Government's proposals for the NHS as set out in Equity and Excellence: Liberating the NHS. During 2012/13 NHS South East London cluster arrangement has been in place which brings together executive roles across the six South East London PCTs with a range of shared functions across the six boroughs and with borough Business Support Units supporting commissioning, the development of clinical commissioning and of health and wellbeing arrangements at a borough level. From 1st October 2012 the South London Commissioning Support Unit (SLCSU) has been operating in shadow form bringing together SE and SW London cluster teams across a range of support functions such as finance and acute commissioning.

Since 2011/12 clinical commissioning in Lambeth has been taken forward by the Lambeth Clinical Commissioning Collaborative Board, with specific delegated authority from the Lambeth PCT Board. Lambeth PCT has also worked with London Borough of Lambeth to develop shadow Health and Well Being arrangements to support the transition towards the transfer of responsibilities for public health and health improvement to local government from April 2013.

The following pages set out the PCT's audited Annual Accounts for 2012/13.

Further copies of the PCT's 2012/13 Final Accounts and Annual Report can be obtained from:
Christine Caton
NHS Lambeth Clinical Commissioning Group
1 Lower Marsh, London SE1 7NT
Telephone 0203 049 4133
e-mail:christine.caton@nhs.net

2 Lambeth's Population and Local Health Issues

Overview

Lambeth is one of the thirteen inner London Boroughs. The Borough runs from the Southbank of the River Thames through Kennington, Brixton, Clapham and Herne Hill to Streatham and Norwood in the south of the Borough. Lambeth is among the most densely populated boroughs in the country and its already rapidly growing population is projected to grow from 304,481 in 2011 by almost 24% to 376,427 by 2032 according to Greater London Authority (GLA) 2012 round demographic projections SHLAA.

The 2012 round demographic projections published by the GLA, shows Lambeth resident population at 304,481 in 2011, however, the general practice registered population in Lambeth in April 2011 was recorded at 377,624. Lambeth PCT has a high proportion of younger population with approximately 53% accounting for 20-44 year olds which is relatively higher than the England average of 35% for that age group.

The population of Lambeth is culturally rich and diverse. Of the total resident population in Lambeth, approximately 37% are from black and minority ethnic groups, which includes the newly arrived asylum seekers and refugees, primarily from Eastern Europe, the Middle East and East Africa. In addition to this, formation of the European Economic Area has also seen an influx of Polish migrants in significant numbers moving into Lambeth over the years, as identified through the local Workers Registration Scheme records. Around 21% of people in the inner London boroughs speak a foreign language at home. Based on reports from schools, approximately 130 different languages are spoken by families in the Borough, with the most common languages, after English, being Yoruba and Portuguese.

Lambeth is one of the most deprived boroughs compared to other parts of England and Wales, including other inner city areas. A higher than average number of children are living in poverty and there are also more 'Looked After Children'. There is a higher proportion of pensioners receiving income support compared to the rest of the country. The employment rate in Lambeth in June 2010 was 74%; with 18% people rated as economically inactive and 9% as unemployed (Local economic assessment, Lambeth, Mar 2011).

Lambeth residents are more likely to experience poorer health and have greater need for health services. This, combined with its diverse ethnic and cultural mix, and a young mobile population provides the PCT and its partners with unique challenges and opportunities for improving health and delivering health care at a community level. Reducing health inequalities is a core aim for the NHS and Local Authority.

Lambeth residents' survey 2011 shows that majority of residents - 71% - rate their health as good or very good and 7 in 10 (70%) respondents in the survey, say local health services are good or excellent. Lambeth people describe themselves as happy and satisfied with their life and where they live. Satisfaction with GP services is high, with over 50% people reported a score of 7 or 8 out of 10 (with 10 being extremely satisfied).

Lambeth has a high level of health need. Life expectancy is lower and premature mortality is higher for a number of conditions including circulatory diseases, cancers, and respiratory conditions. There are other high levels of health needs in Lambeth such as long-term conditions (diabetes, cancer, coronary heart disease and respiratory diseases), mental health, HIV, sexual health, substance misuse and childhood obesity.

Lambeth has seen an improvement in the life expectancy for both men and women from baseline year 1995-1997 to present by 5.4 years for men (to 77.0 years in 2008-10) and 2.7 years for women (to 81.1 years in 2008-10). The gap in life expectancy between Lambeth and England has also reduced (more in males than females). Higher than average rates of smoking, alcohol and drug use and sexually transmitted infections all will impact on the life expectancy of Lambeth residents.

In recognition of the high level of health need in the Borough, NHS Lambeth was identified as one of the "Spearhead PCTs" in the country. This involved additional implementation of initiatives aimed at tackling the major causes of health inequalities within the borough to improve health and increase life expectancy. Lambeth is one of the few spearhead PCTs that is currently on track to reduce the gap in life expectancy compared to England (i.e. life expectancy has been improving faster in Lambeth compared to England as a whole).

The PCT, with our partners, has identified severe mental illness, stopping smoking, management of long term conditions in particular cardiovascular disease and diabetes, childhood obesity and HIV prevention as its six priority health goals in the five year strategy going forward.

Whilst Lambeth has had one of the highest rates of teenage pregnancy, this has declined significantly over successive years. The teenage conception rate has fallen from 102 in 2003 to 34.8 in 2011 (per 1000 females aged 15-17 years); which is a decline of over 66% in the past seven years, the fastest in the country. However the number of sexually transmitted infections seen at local genito-urinary medicine clinics and the prevalence of diagnosed HIV individuals in treatment and resident in Lambeth, continues to be high.

3 Lambeth PCT 2012/13 Performance against Statutory Financial Duties

In line with other NHS bodies Lambeth PCT is required to prepare annual accounts on a resource accounting basis and is required by statute to meet certain financial duties to ensure that public funds are used appropriately.

These duties are:

(i) not to exceed its Revenue Resource Limit and Capital Resource Limit and its (combined revenue and capital) Cash Limit.

(ii) to absorb capital costs in full through a charge calculated at 3.5% of the average relevant net assets of the PCT.

(iii) to demonstrate full cost recovery, on an accruals basis, in relation to provider functions. This is no longer applicable to Lambeth PCT with the transfer of Community Services to Guys and St Thomas' Foundation Trust

In 2012/13 Lambeth PCT achieved in full its statutory financial duties as follows:

(i) Revenue and Capital Resource Limits and combined Cash Limit

Lambeth PCT underspent against its 2012/13 Revenue Resource Limit by £7.093 million (1.00%) (note 3.1) and by £305K (1.22%) against its 2012/13 Capital Resource Limit (note 3.2).

Lambeth PCT under drew its 2012/13 Cash Limit by £9m in line with forecasts provided to NHS London.

The PCT has demonstrated financial balance without the need for the receipt of unplanned financial assistance. The following table shows the 2012/13 outturn

	Revenue Resource Limit	Capital Resource Limit	Total
	£000	£000	£000
Resource Limit 2012/13	712,269	24,955	737,224
Charge against Resource Limit	705,176	24,650	729,826
Underspend	7,093	305	7,398
% Underspend	1.00%	1.22%	1.00%

Under the Department of Health year-end carry forward arrangements Revenue Resource Limits underspends or overspends reported at Month 12 2011/12 will be recovered by PCTs in 2012/13. Underspends against Capital Resource Limits are not carried forward. PCTs bid for capital resources on an annual basis.

(ii) Payment of Capital Charges

Lambeth PCT paid over in full capital charges to the Department of Health in respect of assets held by the PCT.

(iii) Provider Full Cost Recovery

Since 2011/12 this target is no longer applicable because Lambeth PCT did not directly provide patient services having transferred Community Health Services to Guys and St Thomas' Foundation Trust with effect from 1st April 2011.

International Financial Reporting Standards

International Financial Reporting Standards (IFRS) are accounting standards issued by the International Accounting Standards Board (IASB). The Chancellor's 2007 Budget announced that the accounts of central government departments and entities in the wider public sector will be produced using IFRS, as interpreted for the public sector in the IFRS-based Financial Reporting Manual (FReM). As a result, IFRS was implemented across the NHS from 2009/10 and is now fully embedded in the financial reporting framework.

Use of Resources Assessment / Value for Money Review

From 2008/09 PCTs were assessed under the Use of Resources (UoR) assessment developed by the Audit Commission which replaced the Auditors Local

Managing Finances – Sound and Strategic Financial Management
Governing the Business – Strategic Commissioning and Good Governance
Managing Resources – Effective Management of Natural Resources Assets and People.

The UoR assessment was scored by its external auditors on four levels, with level four defined as performing strongly.

NHS Lambeth scored an overall score of 4 (excellent) in the ALE assessment, for 2007/08. The PCT was one of 11 out of 152 PCTs to score a level 3 in the Use of Resources assessment for 2008/09 and sustained this performance in 2009/10. It has consistently achieved an unqualified value for money assessment.

In 2010/11 the UoR assessment was replaced as the Audit Commission reviewed its approach to auditor's work to ensure that it is more targeted and gives better value. From 2010/11 Auditors give their statutory Value for Money (VFM) conclusion on the arrangements to secure economy, efficiency and effectiveness based on two criteria:

(i) securing financial resilience - focusing on whether the PCT is managing its financial risks to secure a stable financial position for the foreseeable future

(ii) challenging how it secures economy, efficiency and effectiveness - focusing on whether the PCT is prioritising its resources within tighter budgets and improving productivity and efficiency.

This has been the subject of VFM Review by external audit since 2010/11. Lambeth PCT received an unqualified VFM opinion in 2011/12. The Review took account of the significant demands placed on the NHS as a result of the transition towards the implementation of the Health and Social Care Act (2012).

Counter Fraud & Corruption

Lambeth CCG have a Counter Fraud Strategy in place in support of the CCG's Counter Fraud and Corruption Policy. The Strategy has enabled the organisation to successfully reduce fraud through a strategic approach, ensuring that all involved in both the provision and use of the services are engaged in countering fraud and corruption.

An agreed protocol is in place with London Borough of Lambeth to work together to prevent and detect fraud within the Borough. Lambeth CCG's Counter Fraud activities are informed by best practice guidance provided by the NHS Protect in accordance with NHS Standards for Providers. Lambeth CCG's last annual Qualitative Assessment (QA) took place in 2010/2011 where they were rated at a Level 3 (performing well) demonstrating an embedded anti-fraud culture within the organisation. NHS Protect suspended the QA process for 2011/12 and 2012/13 in order for them to review the process.

Lambeth CCG are compliant with the Bribery Act 2010 which has serious consequences for organisations that do not have sufficient preventative measures in place. The Counter Fraud team have held various Fraud awareness campaigns across the organisation to create awareness amongst staff including conducting presentations, fraud stands and distribution of articles. In addition to this it has been identified as a risk and incorporated within the finance risk register. Key polices policies including Whistle blowing; Hospitality and Gifts policies have been updated to reflect the requirements of the Bribery Act

4 Corporate Governance

The PCT had in place corporate governance arrangements that have been approved by the Cluster PCT Board in 2011 and are set out in the *Corporate Governance and Accountability Framework*. This includes detailed Standing Orders and Standing Financial Instructions. During 2012/13 the PCT Cluster Board kept its governance arrangements under review to ensure that they remain fit for purpose and have made a number of changes to the subcommittee structure.

There was an established Board Assurance Framework and supporting risk register in place as part of our regular integrated Performance and Reporting Framework built upon our annual business plan objectives.

5 Liberating the NHS - The Health & Social Care Bill

The government published its White Paper, Equity and Excellence: Liberating the NHS in July 2010, setting out its long-term vision for the future of the NHS. The White Paper set out how the government intends to put patients at the heart of everything the NHS does, focus on continuously improving those things that really matter to patients - the quality and outcome of their healthcare and empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services.

For PCTs the key proposals include:

- Commissioning - the transfer of Commissioning responsibility from PCTs to Clinical Commissioning Consortia and the NHS National Commissioning Board, leading to the abolition of Strategic Health Authorities (SHAs) and PCTs.

- Public Health and wellbeing: including the creation of a national Public Health service and the transfer of health improvement functions to local government

- Resources: the government has restated its commitment to real terms increases in funds for health, to the need for the NHS to deliver £20 billion efficiency savings and the reduction in NHS management costs by 45 per cent over the next four years.

The Health and Social Care Bill was presented to Parliament in January 2011 and was passed in March 2012. The Department of Health has provided guidance on developments in managing the transition over the period of the implementation of the Bill. The criticality of ensuring day-to-day delivery of high standards of clinical care and the importance of ensuring that patients rights are met as set out in the NHS Constitution, including timeliness of diagnosis and treatment, have been reaffirmed.

It is intended that commissioning is outward facing with commissioners drawing on patients, the public, clinicians, partners and staff to shape new patterns of care and develop longer term system-wide solutions to the QIPP challenge. The new system has involved developing an integrated commissioning system including progress to establishing the National Commissioning Board, Clinical Commissioning Consortia pathfinders and early implementer Health and Wellbeing Boards. The new system is supported by key enablers in patient information, empowerment and choice, informatics, education and training, public health and human resources and the national approach to development in these areas.

Clinical Commissioning and CCG Authorisation

The PCT continued to work with local practices, communities and partners in the development of clinical commissioning throughout 2012/13. This resulted in NHS Lambeth being fully authorised, as part of the national authorisation process, without conditions in phase 2 of authorisation on 18th January 2013. The process included submission of evidence, including sign up of all Lambeth practices to the NHS Lambeth Constitution, a site visit to demonstrate delivery on key competences and 119 criteria. The CCG operated in shadow form from January to March 2013 with the Lambeth Clinical Commissioning Board a formal sub-committee of South East London Cluster of PCTs throughout 2012/13. The Board was chaired by Dr Adrian McLachlan and included six other local clinicians, two representatives from each of the North, South East and South West localities, the Director of Public Health, the Managing Director of Lambeth Business Support Unit, the London Borough of Lambeth Director of Adult Services . Lambeth LINk and Kings Health partners were co-opted to the board and the Lambeth Local Medical Committee had observation status. The LCCCB was supported by Lambeth Business Support Unit and staff based in the South East London Cluster of PCTs. Full delegation of budgets was achieved in the previous year with the delegation of acute budgets to the Lambeth Clinical Commissioning Collaborative Board in January 2012.

Health and Well Being Board

Lambeth was an Early Implementer Health and Well Being site. During 2011 a series of facilitated workshops involving partners from across the NHS, voluntary sector, council and others were held to inform the development, focus and governance of the Health and Wellbeing Board. The first meeting of the shadow board took place at the end of April 2012 and has continued to meet during 2012/13. It is chaired by the member for Health and Adult Services, with co-chairs from Children and Young people's (Members) and the Lambeth Clinical Commissioning Board (Chair). The Lambeth Health and Wellbeing Strategy is well developed through close working with partners and Lambeth communities and informs the Lambeth approach to health improvement and reduction in health inequalities.

Trust Special Administrator (TSA) work across South East London

On 16 July 2012 the Secretary of State for Health appointed a Trust Special Administrator (TSA) to South London Healthcare Trust under the Regime for Unsustainable NHS Providers (UPR). He was appointed to make recommendations on how to deliver a lasting clinical and financial solution for the Trust. Following a period of consultation, the Secretary of State broadly accepted the recommendations in the TSA's final report as follows:

- Lewisham Hospital to retain its A&E
- South London Healthcare Trust to be dissolved, with each of its hospitals being taken over by a neighbouring hospital Trust (subject to the approval of the relevant regulators)
- All three hospitals within South London Healthcare NHS Trust - Queen Elizabeth Hospital in Woolwich, Queen Mary's in Sidcup and the Princess Royal in Bromley to make the full £74.9 million of efficiencies identified by the Trust Special Administrator.
- All vacant or poorly utilised premises to be vacated sold where possible.
- The Department of Health to pay for the excess costs of the PFI buildings at the Queen Elizabeth and Princess Royal Hospitals and write off the accumulated debt of the Trust so that the new organisations are not saddled with historic debts. It will also provide an appropriate level of transitional funding to cover implementation planning and subsequent implementation.

Health Act Partnerships and Integrated Commissioning

During 2012/13 NHS Lambeth has continued to have Section 75 Agreements with the London Borough of Lambeth and local Foundation Trusts for:

- Adult Mental Health Services
- Integrated Community Equipment Store
- Delayed Discharges Arrangements
- Free Nursing Care

The Section 75 for Deprivation of Liberty Safeguards was terminated on 31st March 2013 to reflect the transfer of funding to the LB Lambeth.
NHS Lambeth and the London Borough of Lambeth are currently reviewing all Section 75 arrangements.

In 2010/11 the PCT strengthened its integrated working with the London Borough of Lambeth by appointing a joint Director of Integrated commissioning to oversee commissioned services across health and social care.

Integration of Community Services into Guy's and St Thomas' NHS Foundation Trust

Under national guidance PCTs were required to have determined the preferred future organisational direction for their community services by 31st March 2010 and implemented these changes by the end of 2010/11. On 25th March 2010, the Lambeth PCT and Southwark PCT Boards considered the recommendations of the Joint Committee of the two PCTs established to oversee this process, and approved Guy's and St Thomas' NHS Foundation Trust, on behalf of King's Health Partners, as preferred partner. During 2010/11 the Transformation Partnership Board and the Joint Committee of Lambeth and Southwark PCTs had oversight of a detailed programme of work to enable the transfer to take place. After receiving approval from NHS London and the Competition and Collaboration Panel and formal staff consultation community services transferred to Guy's and St Thomas' NHS Foundation Trust on 1st April 2011.

We continued to work with the trusts to realise the benefits of integration and maintain and improve community services. As part of the Integrated Care Programme, GSTT CHS has piloted HomeWard and Enhanced Rapid Response - services provided in the person's home to prevent attendance at A&E, admission to hospital and long term care and to enable people to be effectively discharged from hospital with ongoing care. We are working with GPs and community matrons to implement a new tool to identify people at risk of crisis and admission to hospital and refer to community matrons for more intensive case management. We have supported increasing recruitment of Health Visitors and further developed the team supporting immunisations to improve uptake in Lambeth. We have commissioned a new Lambeth Early intervention and Prevention Service to improve smoking cessation, reduce levels of adult obesity, support early identification of long term conditions in harder to reach communities and reduce harm due to alcohol consumption.

Primary Care Developments

Primary Care Contracting is undertaken by a single team across the South East London cluster of PCTs. The team works with clinical commissioners and NHS Lambeth staff to improve the quality of primary care services. We have continued to reviewe enhanced services to ensure value for money and equity of funding across Lambeth including support to nursing homes, end of life care and minor surgery. We have reviewed the GP Walk In Centre at Gracefield Gardens leading to changes in opening times to complement other services. We have worked with practices to improve provision of care and health outcomes for people with long terms conditions.
NHS Lambeth has continued to exceed dental access targets set by NHS London and increased access to evening and weekend appointments.

Lambeth has developed its Healthy Living Pharmacies with 22 pharmacies accredited and a wide range of Healthy Living Champions trained to provide advice to people in Lambeth. We have commissioned pharmacies to deliver health checks to identify people at risk of vascular disease.

Brixton Prison

Following a review of performance, NHS Lambeth agreed to extend the contract by a further two years to the consortium led by Care UK LTD, and including South London and Maudsley NHS Foundation Trust and Lambeth Community Health. The prison contract is now in the final year of extension and continues to be overseen by the Strategic Brixton Prison Partnership Board whose membership includes amongst others NHS Lambeth, HMP Brixton, the National Probation Service and the National Treatment Agency.

From April 2012, Brixton prison was re-categorised as a Category C Resettlement prison, and ceased taking remand prisoners from mid-April. Changes from this resulted in the 25-bedded inpatient wing(D-Wing) being closed and health services reconfiguring to deliver an increase in primary care and a change in hours of operation given the need to support the prisoners who are released on temporary licence. Vulnerable prisoners were moved from HMP Wandsworth to Brixton due to refurbishment work taking place on the dedicated wing and this has resulted in an increase in demand for services and also escorts and bedwatches and healthcare have adapted to the change in demand.

Payment by Results, CQUIN and Quality Accounts

In 2012/13, there have continued to be developments in the NHS Payments by Results (PbR) system. Under this national system there is a standard price tariff by which provider trusts are funded for activity undertaken on behalf of PCT populations. The structure of national tariffs in the acute sector is consistently updated including the expansion of the scope of best practice tariffs. During 2012/13 we have been doing preparatory work for the implementation of PbR for Mental Health from 2013/14 which will be an introductory year. This has involved working closely with the South London and Maudsley NHS Trust and local commissioners to validate financial and activity information and agree principles for the management of risk as the new system is implemented.

The Commissioning for Quality and Innovation (CQUIN) payment framework is now well established having been introduced in 2009/10. The key aim is to secure improvements in quality of services and better outcomes for patients, whilst maintaining strong financial management. Improvement goals in 2012/13 reflected national, regional and local priorities. The publication of quality performance information is a requirement within annual Quality Accounts for Acute, Community and Mental Health providers. Guy's and St Thomas' NHS Foundation Trust and South London and Maudsley NHS Foundation Trust quality issues, including priorities identified in Quality Accounts, have been monitored internally by Lambeth Primary Care Trust and externally in the Care Quality Commission throughout 2012/13.

Integrated Care Programme (ICP)

Lambeth is part of Southwark and Lambeth Integrated Care, which is an initiative involving Kings Health Partners, London Boroughs of Lambeth and Southwark, and NHS Lambeth & Southwark. Integrated Care is supporting different services to work better together to provide a more joined up service for patients, with better health outcomes. The key objective of the ICP is to deliver increased value across the whole care system by: joining up care around people, across providers; identifying and managing people's care needs better and intervening earlier and ensuring care is provided in the most appropriate setting, particularly at times of crisis.

During 2012/13 Guy's & St Thomas Community services have supported hundreds of people at home through HomeWard and Enhanced Rapid Response preventing admissions to hospital. we have developed Community Multi-Disciplinary Teams in North lambeth and South East Lambeth bringing together local health and social care staff to identify how to support frail elderly people in the area to improve care and prevent admission to hospital and long term care. Guy's & St Thomas and King's have introduced Rapid Access clinics for older people to speed up diagnosis and telephone advice to GPs and community staff on the care and management of older people. As part of our support for this work, in 2012/13, Lambeth, joint with Southwark, has invested over £2m in developing these new community based services. Work on long term conditions is continuing. The ICP was successful in securing a bid for funding of £4.8m to help support the development of integrated care pathways over a two year period.

Transforming primary and community mental health services for people with severe mental illness - the Lambeth Living Well Collaborative

This work is being led by the Lambeth Living Well Collaborative (a partnership platform of users, carers, GPs, clinicians, providers and commissioners) which aims to use "co-production" as the operating framework for the delivery and commissioning of services and support provided for people with long term mental illness.

It has undertaken extensive engagement with users, carers and partners with over 15 events and 1600 people participating. This has resulted in broad agreement on a much improved service offer which it is currently implementing. This includes building capacity within primary care via the new primary care mental health support service (PASS); recovery focused provision within the Voluntary sector via the Community Options service; a more responsive and easier to navigate secondary care (SLaM); extensive development of peer support networks and the expansion of time banking across the borough.

The overall aim is to support people to take control over their lives through recovery orientated personalised care and support and reduce the dependency on (especially) secondary care services – a common feature of mental health systems nationally as well as in Lambeth.

Guy's & St Thomas' Charity Modernisation Initiative

Under the auspices of the Guy's and St Thomas' Charity Modernisation Initiative the PCT has worked over recent years with Southwark PCT, Kings College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust to implement local service redesign with the implementation of a new diabetes pathway and end of life care. The diabetes programme has developed new out of hospital services for people with Type II diabetes and worked to improve the quality of primary care services. It has developed engagement with people with diabetes, working with clinicians to co-design new ways of providing care and encouraging people to develop confidence in managing their own condition. The end of life care programme has focused on improving the ability of people to die in their place of choice. It has developed improved pathways and sharing of information between services including evenings and weekends.

6 Further Developments

NHS Lambeth Strategic Plan 2010/11 to 2014/15

The 2010/15 Strategic Plan was refreshed for the final three years of the programme. The local Lambeth plan builds on the work undertaken during 2009/10 through a systematic prioritisation exercise working with local partners and stakeholders to agree priority health goals, associated delivery initiatives and outcome measures. The production of the 2010/15 Strategy included developing a five year Quality, Innovation, Productivity and Prevention (QIPP) programme. During 2012/13 Lambeth reviewed its priority health goals and re-affirmed these as being serious mental illness, cardiovascular disease, diabetes, smoking, childhood obesity and HIV prevention. We added a further priority of alcohol in partnership with London Borough of Lambeth . A comprehensive QIPP programme has been developed covering staying healthy, pathway redesign in planned and unplanned care, cancer and cardio- vascular disease, the Lambeth Living Well Collaborative for mental health, forensic services and primary care.

NHS Lambeth CCG is currently revisiting the existing Lambeth Strategic Plan, working closely with local stakeholders, partners and commissioners to draft a new Strategic Plan that acknowledges the increasingly challenging health needs and financial context and reflects the new commissioning system. We are reviewing the potential to transform services or the way in which they are delivered to ensure that we are building a sustainable and quality centred local health care system.

Our Commissioning Strategy Plan can be accessed at the NHS Lambeth CCG website - **www.lambethccg.nhs.uk**

Equality and Equity Scheme

During 2011/12 NHS Lambeth revised its approach to equality and human rights to be more in line with the Equality Act (2010). The Act widens the legally protected population groups and requires a more encompassing process of equality analysis and public engagement that focuses on outcomes rather than on individual impact assessments. The NHS developed an 'Equality Delivery System' to support this and NHS Lambeth participated in a coordinated approach organised by NHS South East London. Partnership working across NHS organisations has enabled sharing of good practice and the development of joint commitments on leadership and employment across NHS commissioners in south east London. In line with the action plan for NHS Lambeth agreed by the new clinical commissioning board at its September 2011 meeting:

- Information to supplement the Joint Strategic Needs C221 baseline information on equality in health and health services for protected groups was published on January 31st 2012

- In early 2012 public health and commissioners reviewed findings on equality impact in 6 priority areas plus the new priority; alcohol so as to identify progress and gaps. After testing ideas out with stakeholders an equality objective was agreed for each strategic priority. These were published in April 2012.

- During 2012/13 work to progress equality objectives was driven through the PCT's Strategic Plan and programme management arrangements.NHS Lambeth also worked closely with Lambeth Council on impact assessments of the benefit cuts and other reductions in local authority expenditure. The PCT also presented 3 of its priority impact assessments to the Council's Equality Impact Assessment Panel; HIV Care and Support, Long Term Conditions, and Talking Therapies recommissioning. Towards the end of 2012/13 NHS Lambeth embarked on a review of progress against the objectives and published a report on 31st January 2013. Following this a round of stakeholder engagement was implemented to gain feedback on progress against the objectives culminating in a large event in late March 2013. The findings will provide the new CCG with an external assessment of progress and revised objectives for 2013/14

NHS Connecting for Health

During 2012/13 Lambeth PCT has actively worked with partners to implement the National Programme for Information Technology (NPfIT). Lambeth completed the rollout out of the Summary Care Record and successfully implemented Electronic Prescription Service across all practices and pharmacies, working with Pharmacy system providers to ensure that the full benefits of this system are achieved across care settings. The rollout was predicated on the successful implementation of EMIS Web and the GP Refresh programme which has seen almost two thirds of the GP infrastructure replaced or upgraded. Greater network speeds have also been achieved through the national Next Generation Architecture (NGA) project which has seen an increase of N3 speeds to General Practice of up to 40Mb/Sec which serves to make spine enabled applications more responsive.

Premises Developments and Local Improvement Finance Trust (LSL LIFT)

As part of the combined initiative between Lambeth, Southwark and Lewisham PCTs, Lambeth PCT was approved as one of 24 areas in England to develop a third wave NHS Local Improvement Finance Trust (LIFT) scheme. LIFT is part of the NHS Plan commitment for the NHS to enter into public-private partnership to improve the quality of, and access to, primary and community-based health services. From 2003/04 Lambeth PCT, along with our partners, undertook a procurement exercise to identify a preferred private sector partner (Building Better Healthcare). In December 2005, the PCT successfully achieved financial close for the first sample schemes (including the Gracefield Gardens Primary and Social Care Centre), the establishment of the Building Better Health - Lambeth Southwark and Lewisham Ltd and the LSL LIFT Strategic Partnership Agreement. In September 2007, the PCT Board approved the Stage 1 Business Case for second tranche schemes known as Akerman Health Centre (Myatts Field) and NHS Baldry Gardens (Streatham Common).

In March 2009, the Board approved the Stage 2 Business case for NHS Baldry Gardens, financial close was achieved in May 2009 and the new facility was completed in June 2010. In January 2010, the Board approved the Stage 2 Business Case for Akerman Heath Centre, financial close was achieved in November 2010 and the building, currently undergoing construction and was completed in August 2012. The Stage 2 Business Case for a new scheme at Norwood Hall was approved by the Joint SE London Board and by NHS London in March 2012. Financial close was achieved in April 2012 and the building is due to be completed in early 2014.

In addition to new schemes developed through LIFT, the PCT has had an ambitious Strategic Capital Development Programme in place to support the provision of high quality services in primary and community based settings. The Clapham One development (now known as the Mary Seacole Centre) became operational in March 2012, and a major service reconfiguration of the LCCC was approved as part of the 12/13 Strategic Capital Development Programme. Akerman Health Centre opened in August 2012 and Norwood Hall is due to open in January 2014. The Business Case for the development of new premises for the Palace Road Practice has been approved by Lambeth PCT.

The PCT Board agreed its third LIFT Strategic Service Development Plan (SSDP) in March 2008. The recommendations of the SE London wide Estates Strategy were approved in February 2012.

Sustainability

Lambeth PCT is fully committed to sustainability as a core value and have registered with the Good Corporate Citizenship Assessment Model, covering travel, procurement, facilities management, workforce, community engagement and buildings. The Lambeth PCT Board approved the Sustainable Development Management Plan in March 2010. This set out our vision to create a `greener' and more sustainable organisation, and committed us to achieve a carbon reduction of ten per cent by 2015. We have continued to aim to become more sustainable by using and wasting less energy and producing less carbon, reducing unnecessary travel and encouraging sustainable procurement using best practice as set out in the NHS Carbon Reduction Strategy - "Saving Carbon, Saving Lives".

STATEMENT OF THE RESPONSIBILITIES OF THE SIGNING OFFICER OF THE PRIMARY CARE TRUST 2012-13 ACCOUNTS

The Department of Health's Accounting Officer has designated the role of signing officer for the final accounts of Lambeth Primary Care Trust to discharge the following responsibilities for the Department of Health:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the primary care trust;

- the expenditure and income of the primary care trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, and from the assurances provided by the PCT Accountable Officer until 31 March 2013, I am assured that the responsibilities have been properly discharged.

Signed.....C V Vincent.....

Date.....31/5/13.....

Carl Vincent
Director of Provider Finance and Finance Transition
Department of Health Designated Signing Officer

2012/13 Accounts Certificate of Assurance to the Department of Health Director General, Strategy Finance and NHS

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Lambeth Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that for the year ended 31 March 2013 based on my own knowledge of internal control matters and through experience in my role as Accountable Officer until 31 March 2013, the PCT:

- had in place effective management systems to safeguard public funds and assets and assist in the implementation of corporate governance;
- kept proper accounting records which disclosed with reasonable accuracy at any time the financial position
- took reasonable steps for the prevention and detection of fraud and other irregularities;
- achieved value for money from the resources available to the PCT;
- applied income and expenditure to the purposes intended by Parliament and conformed to the authorities which governed them; and
- had effective and sound financial management systems in place.

I also confirm that in my role overseeing the preparation of the annual statutory accounts, the accounts were prepared in the format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year. As required the accounts;

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

Andrew Kenworthy
Accountable Officer 2012/13

Signature: 

Date: 24 April 2013

2012/13 Accounts Certificate of Financial Assurance to the Department of Health Director Strategy Finance and NHS

I am aware that as signing officer designated by the Department of Health Accounting Officer, you are required to sign the accounts and supporting certificates of Lambeth Primary Care Trust (PCT) in order to comply with the Department's 2012/13 accounts finalisation process.

To assist you in that process, I can confirm that in my role managing the preparation of the annual statutory accounts, the accounts were prepared in the format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year. As required the accounts:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

Richard Chapman
Director of Finance SEL Cluster 2012/13

Signature: 

Date: 24 April 2013

INDEPENDENT AUDITORS' REPORT TO THE ACCOUNTABLE OFFICER FOR LAMBETH PRIMARY CARE TRUST

We have audited the financial statements of Lambeth Primary Care Trust for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 42. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes; and
- the table of pay multiples and related narrative notes

This report is made solely to the Accountable Officer for Lambeth Primary Care Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. Our audit work has been undertaken so that we might state to the PCT those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Primary Care Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Signing Officer and auditors

As explained more fully in the Accounts Certificate of Assurance to the Department of Health Director General, Strategy, Finance and NHS, the Signing Officer is responsible for overseeing the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on regularity

In our opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Lambeth Primary Care Trust as at 31 March 2013 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998

We have nothing to report in these respects

Conclusion on the PCT's arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report any matters that prevent us being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in November 2012. We have considered the results of the following:

- our review of the Governance Statement;

- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the Trust; and

- our locally determined risk-based work on the financial resilience of the PCT.

As a result, we have concluded that there is nothing to report.

Certificate

We certify that we have completed the audit of the accounts of Lambeth Primary Care Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Matthew Hall

Matthew Hall (Engagement Lead)
for and on behalf of Deloitte LLP
Appointed Auditor
St Albans, UK

6 June 2013

Statement of Comprehensive Net Expenditure for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Administration Costs and Programme Expenditure			
Gross employee benefits	7.1	**27,164**	21,588
Other costs	5.1	**725,513**	695,903
Income	4	**(49,523)**	(38,433)
Net operating costs before interest		**703,154**	679,058
Investment income	9	**(127)**	(9)
Other (Gains)/Losses	10	**0**	(19)
Finance costs	11	**2,149**	1,420
Net operating costs for the financial year		**705,176**	680,450
Transfers by absorption -(gains)		**0**	
Transfers by absorption - losses		**0**	
Net (gain)/loss on transfers by absorption		**0**	
Net Operating Costs for the Financial Year including absorption transfers		**705,176**	**680,450**
Of which:			
Administration Costs			
Gross employee benefits	7.1	**23,173**	18,050
Other costs	5.1	**25,810**	14,168
Income	4	**(25,356)**	(20,013)
Net administration costs before interest		**23,627**	**12,205**
Investment income	9	**0**	0
Other (Gains)/Losses	10	**0**	0
Finance costs	11	**0**	0
Net administration costs for the financial year		**23,627**	**12,205**
Programme Expenditure			
Gross employee benefits	7.1	**3,991**	3,538
Other costs	5.1	**699,703**	681,735
Income	4	**(24,167)**	(18,420)
Net programme expenditure before interest		**679,527**	**666,853**
Investment income	9	**(127)**	(9)
Other (Gains)/Losses	10	**0**	(19)
Finance costs	11	**2,149**	1,420
Net programme expenditure for the financial year		**681,549**	**668,245**

Other Comprehensive Net Expenditure	2012-13 £000	2011-12 £000
Impairments and reversals put to the Revaluation Reserve	**1,245**	1,393
Net (gain) on revaluation of property, plant & equipment	**(538)**	0
Net (gain) on revaluation of intangibles	**0**	0
Net (gain) on revaluation of financial assets	**0**	0
Net (gain)/loss on other reserves	**0**	0
Net (gain)/loss on available for sale financial assets	**0**	0
Net (gain) /loss on Assets Held for Sale	**0**	
Release of Reserves to Statement of Comprehensive Net Expenditure	**0**	
Net actuarial (gain)/loss on pension schemes	**0**	0
Reclassification Adjustments		
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive net expenditure for the year*	**705,883**	**681,843**

*This is the sum of the rows above plus net operating costs for the financial year after absorption accounting adjustments.
The notes on pages 18 to 55 form part of this account.

Statement of Financial Position at 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets:			
Property, plant and equipment	12	72,073	54,472
Intangible assets	13	0	0
investment property	15	0	0
Other financial assets	21	719	719
Trade and other receivables	19	0	0
Total non-current assets		72,792	55,191
Current assets:			
Inventories	18	0	0
Trade and other receivables	19	8,093	11,355
Other financial assets	36	0	0
Other current assets	22	0	0
Cash and cash equivalents	23	26	19
Total current assets		8,119	11,374
Non-current assets held for sale	24	0	0
Total current assets		8,119	11,374
Total assets		80,911	66,565
Current liabilities			
Trade and other payables	25	(40,403)	(39,478)
Other liabilities	26,28	0	0
Provisions	32	(3,443)	(1,556)
Borrowings	27	(356)	(53)
Other financial liabilities	36.2	0	0
Total current liabilities		(44,202)	(41,087)
Non-current assets plus/less net current assets/liabilities		36,709	25,478
Non-current liabilities			
Trade and other payables	25	0	0
Other Liabilities	28	0	0
Provisions	32	(1,939)	0
Borrowings	27	(35,588)	(17,037)
Other financial liabilities	36.2	0	0
Total non-current liabilities		(37,527)	(17,037)
Total Assets Employed:		(818)	8,441
Financed by taxpayers' equity:			
General fund		(11,379)	(2,827)
Revaluation reserve		10,561	11,268
Other reserves		0	0
Total taxpayers' equity:		(818)	8,441

The notes on pages 18 to 55 form part of this account.

The financial statements on pages *14 to 17* were approved by the DH Audit Committee on 31 May 2013 and signed on its behalf by

CVincent

Carl Vincent
Director of Provider Finance and Finance Transition

Date: 31/5/13

Statement of Changes In Taxpayers Equity for the year ended 31 March 2013

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2012	**(8,177)**	**11,268**	**0**	**3,091**
Opening Balance Adjustment	**5,350**			**5,350**
Balance at 1 April 2012 Re-stated	**(2,827)**	**11,268**		**8,441**
Changes in taxpayers' equity for 2012-13				
Net operating cost for the year	(705,176)			**(705,176)**
Net gain on revaluation of property, plant, equipment		538		**538**
Net gain on revaluation of intangible assets		0		**0**
Net gain on revaluation of financial assets		0		**0**
Net gain on revaluation of assets held for sale		0		**0**
Impairments and reversals		(1,245)		**(1,245)**
Movements in other reserves			0	**0**
Transfers between reserves*	0	0		**0**
Release of Reserves to SOCNE		0		**0**
Reclassification Adjustments				
Transfers between Revaluation Reserve & General Fund in respect of assets transferred under absorption	0	0		**0**
Net actuarial gain/(loss) on pensions	0		0	**0**
Total recognised income and expense for 2012-13	**(705,176)**	**(707)**	**0**	**(705,883)**
Net Parliamentary funding	696,624			**696,624**
Balance at 31 March 2013	**(11,379)**	**10,561**	**0**	**(818)**

Balance at 1 April 2011	**(5,669)**	**12,733**	**0**	**7,064**
Changes in taxpayers' equity for 2011-12				
Net operating cost for the year	(680,450)			(680,450)
Net Gain / (loss) on Revaluation of Property, Plant and Equipment		0		0
Net Gain / (loss) on Revaluation of Intangible Assets		0		0
Net Gain / (loss) on Revaluation of Financial Assets		0		0
Net Gain / (loss) on Assets Held for Sale		0		0
Impairments and Reversals		(1,393)		(1,393)
Movements in other reserves			0	0
Transfers between reserves*	72	(72)		0
Release of Reserves to Statement of Comprehensive Net Expenditure		0		0
Reclassification Adjustments				
Transfers to/(from) Other Bodies within the Resource Account Boundary	60	0	0	60
On disposal of available for sale financial assets	0	0	0	0
Net actuarial gain/(loss) on pensions	0		0	0
Total recognised income and expense for 2011-12	(680,318)	(1,465)	0	(681,783)
Net Parliamentary funding	677,810			677,810
Balance at 31 March 2012	**(8,177)**	**11,268**	**0**	**3,091**

Statement of cash flows for the year ended 31 March 2013

	2012-13 £000	2011-12 £000
Cash Flows from Operating Activities		
Net Operating Cost Before Interest	(703,154)	(679,058)
Depreciation and Amortisation	1,804	1,429
Impairments and Reversals	4,538	616
Other Gains / (Losses) on foreign exchange	0	0
Donated Assets received credited to revenue but non-cash	0	0
Government Granted Assets received credited to revenue but non-cash	0	0
Interest Paid	(2,149)	(1,420)
Release of PFI/deferred credit	0	0
(Increase)/Decrease in Inventories	0	0
(Increase)/Decrease in Trade and Other Receivables	3,574	(3,392)
(Increase)/Decrease in Other Current Assets	0	0
Increase/(Decrease) in Trade and Other Payables	1,341	7,634
(Increase)/Decrease in Other Current Liabilities	0	0
Provisions Utilised	(16)	(1,572)
Increase/(Decrease) in Provisions	3,842	510
Net Cash Inflow/(Outflow) from Operating Activities	(690,220)	(675,253)
Cash flows from investing activities		
Interest Received	127	9
(Payments) for Property, Plant and Equipment	(6,035)	(1,611)
(Payments) for Intangible Assets	0	0
(Payments) for Other Financial Assets	0	0
(Payments) for Financial Assets (LIFT)	0	0
Proceeds of disposal of assets held for sale (PPE)	41	230
Proceeds of disposal of assets held for sale (Intangible)	0	0
Proceeds from Disposal of Other Financial Assets	0	0
Proceeds from the disposal of Financial Assets (LIFT)	0	0
Loans Made in Respect of LIFT	0	0
Loans Repaid in Respect of LIFT	0	0
Rental Revenue	0	0
Net Cash Inflow/(Outflow) from Investing Activities	(5,867)	(1,372)
Net cash inflow/(outflow) before financing	(696,087)	(676,625)
Cash flows from financing activities		
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	(530)	0
Net Parliamentary Funding	696,624	677,810
Capital Receipts Surrendered	0	0
Capital grants and other capital receipts	0	0
Cash Transferred (to)/from Other NHS Bodies	0	(1,166)
Net Cash Inflow/(Outflow) from Financing Activities	696,094	676,644
Net increase/(decrease) in cash and cash equivalents	7	19
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	19	0
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	0	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	26	19

1. Accounting policies

The Secretary of State for Health has directed that the financial statements of PCTs shall meet the accounting requirements of the PCT Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 PCTs Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the PCT Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the PCT for the purpose of giving a true and fair view has been selected. The particular policies adopted by the PCT are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

The PCT is within the Government Resource Accounting Boundary and therefore has only consolidated interests in other entities where the other entity is also within the resource accounting boundary and the PCT exercises in-year budgetary control over the other entity.

In accordance with the directed accounting policy from the Secretary of State, the PCT does not consolidate the NHS charitable funds for which it is the corporate trustee.

As a consequence of the Health and Social Care Act 2012, Lambeth PCT will be dissolved on 31st March 2013. It's functions will be transferred to various new or existing public sector entities.

The Secretary of State has directed that, where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern.

As a result, the Board of Lambeth PCT have prepared these financial statements on a going concern basis.

1.1 Accounting Conventions

The financial statements have been prepared in accordance with EU endorsed International Financial Reporting Standards and IFRIC's as applicable to the NHS under the FReM.

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities

Transforming Community Services (TCS) transactions

Under the TCS initiative, services historically provided by PCTs have transferred to other providers - notably NHS Trusts and NHS Foundation Trusts. Such transfers fall to be accounted for by use of ***absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE, and is disclosed separately from operating costs.***

Acquisitions and Discontinued Operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one NHS body to another.

Critical accounting judgements and key sources of estimation uncertainty

In the application of the PCT's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors, that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the entity's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Revenue recognition

Revenue is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where revenue has been received for a specific activity to be delivered in the following financial year, that revenue will be deferred.

Expenditure related to partially completed contracts for patient services are not accounted for as work-in-progress but expenditure is accrued in respect of part-completed treatment episodes at the statement of financial position date.

Classification of property

The PCT owns a number of properties, which are maintained primarily to provide services. The receipt of market-based rental from these properties is incidental to holding these properties. These properties are held for service delivery objectives as part of the PCT's Community Strategy Plan and Strategic Services Development Plan. These properties are accounted for as property, plant and equipment

1. Accounting policies (continued)

PFI and LIFT

The PCT's accounting policies regarding its LIFT scheme are disclosed in Note 1.26 to these financial statements. The PCT accounts for these assets under IFRIC 12 as a service concession and when the applicable elements of IAS 17 are met these are capitalised.

The PCT initially recognised the LIFT assets and associated finance lease liability at the assets' fair value. The PCT's LIFT asset is being accounted for in two ways, an element as if it was a freehold building and an element as plant and equipment, the accounting judgements and estimation uncertainty for both of which are disclosed below. The PCT has taken the judgement that, due to the uncertainty over the size and structure of the health care economy at the end of the lease, it is unlikely that it will exercise its repurchase option over the LIFT at the end of the lease life. It is therefore depreciating the asset over the life of the lease rather than the asset's useful economic life. The LIFT finance lease liabilities are being amortised over the lives of the lease using the rate of return required by the assets' operators. This rate has been estimated using the assets' operators' financial models, as agreed with the PCT at the schemes' inception, and is estimated to spread that return over the life of the leases.

As part of the PCT's LIFT contract, the LIFT operator provides a Managed Equipment Service ('MES'). Through this service the PCT has access to a wide range of equipment within the scheme, and these assets are maintained and replaced at the end of their useful economic life by the LIFT operator. This PCT has judged that these assets should be held as plant and equipment and therefore, in line with the PCT's accounting policies, depreciated over 5 years. Deferred income has been set up to smooth tenant's income in relation the MES element of the LIFT unitary payment to the MES costs over time.

The PCT recognises the fact that the financial models employed to account for the LIFT scheme profiles the capital additions and capital lease payments on a changeable basis each year, which causes considerable variations in the rental costs taken to the Statement of Comprehensive Net Expenditure from year to year. Subsequent rental charges for the LIFT properties to the PCT's tenants are conversely calculated on a basis which allows a more comparable and predictable charge year on year and smoothes the affect of these variations. The difference between the rental charge to tenants and the charge to the income statement relating to that rental charge is a timing difference and is accounted for as either deferred or accrued income in the year.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments.

Provisions

The significant critical judgments for the PCT's pension provisions are disclosed in Note 7.5.

Redundancy Payment Accruals and Provisions – PCT Reorganisation : The accounts include accruals for redundancies that incurred during March 2013. Number of payments for these redundancies were made in March 2013 and reported as cash expenditure. Payments for redundancies due and not paid have been accrued in the Accounts.

Property, plant, and equipment

The PCT's accounting judgments around its property, plant, and equipment base are the residual lives and value of the PCT assets, which impact the annual depreciation charge and therefore holding amount of the asset, the methodology used to ensure the assets holding amount reflect current cost, particularly around its land and buildings and the application of indexation, and the timing of when asset are capitalised (brought into use) and derecognised (and moved to assets held for resale and to be disposed off).

where there is no formal lease but where there is a substance of a lease as require by IFRIC 4. The PCT will decide on whether to recognise leases as finance or operating leases using the criteria laid down by IAS 17 with a rebuttable presumption that leases where the net present of future lease payments exceeds 90% of the asset's fair value at the inception of the lease the lease will be capitalised as a finance lease. Where other factors suggest a finance lease category better reflects the substance of the transaction and the transfer of risks and rewards of the leased asset the PCT will capitalise the lease even if the 90% target is not met.

Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

The Primary Care Trust has exercised its judgement on the appropriate classification of building leases and has determined a number of lease arrangements are finance leases.

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

Recoverability of NHS debtors

The PCT does not provide against amounts due from other NHS bodies and believes that these amounts are recoverable in full.

Provisions

The significant estimation uncertainties for the PCT's pension provisions are disclosed in Note 7.5.

The PCT's material provision is for Continuing Healthcare Costs in note 32. The PCT does not believe that it has material estimation uncertainty over the completeness of its provisions. Contingent liabilities are disclosed in Note 33

Property, plant, and equipment

The PCT's estimates regarding property, plant, and equipment used are disclosed in Note 1.7. They are annually reviewed by the PCT, using external specialist advice where appropriate. Where there is indication that the PCT's assets are impaired, the estimation technique used to calculate the level of impairment is to compare the current holding amount of the asset to the assets fair value as derived by a professional valuer and using a valuation basis suitable for the asset (normally open market value for alternative use). The difference is then accounted for in line with the applicable accounting standards.

1. Accounting policies (continued)

1.2 Revenue and Funding

The main source of funding for the Primary Care Trust is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the Primary Care Trust. Parliamentary funding is recognised in the financial period in which the cash is received.

Miscellaneous revenue is income which relates directly to the operating activities of the Primary Care Trust. It principally comprises fees and charges for services provided on a full cost basis to external customers, as well as public repayment work. It includes both income appropriated-in-aid of the Vote and income to the Consolidated Fund which HM Treasury has agreed should be treated as operating income.

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where revenue has been received for a specific activity to be delivered in the following financial year, that income will be deferred.

1.4 Pooled budgets

The section 75 pooled fund agreement for Learning Disabilities was terminated with effect from 1 April 2012 to reflect the changes in arrangements resulting from the implementation of the Valuing People policy. There are from that date no pooled budgets

1.5 Taxation

The PCT is not liable to pay corporation tax. Expenditure is shown net of recoverable VAT. Irrecoverable VAT is charged to the most appropriate expenditure heading or capitalised if it relates to an asset.

1.6 Administration and Programme Costs

Treasury has set performance targets in respect of non-frontline expenditure (administration expenditure).
From 2011-12, PCTs therefore analyse and report revenue income and expenditure by "admin and programme"
For PCTs, the Department has defined "admin and programme" in terms of running costs.

The broad definition of running costs includes any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.
Expense incurred under NHS transition redundancy programmes is however classed as "programme" under Treasury budgetary control arrrangements and so is recorded as such in the financial statements.

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the PCT;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the PCT's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

1. Accounting policies (continued)

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net expenditure in the Statement of Comprehensive Net Expenditure

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.8 Intangible Assets

The PCT has no intangible assets in 2012/13 (2011/12 Nil).

1.9 Depreciation, amortisation and impairments

Freehold land, properties under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the PCT expects to obtain economic benefits or service potential from the asset. This is specific to the PCT and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives

At each reporting period end, the PCT checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1. Accounting policies (continued)

1.10 Donated assets

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been

1.11 Government grants

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.12 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset in the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.13 Inventories

The PCT had no assets classified as inventories either in 2012/13 or in 2011/12.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the PCT's cash management.

1.15 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings including losses which would have been made good through insurance cover had PCTs not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1. Accounting policies (continued)

1.16 Clinical Negligence Costs

From 1 April 2000, the NHS Litigation Authority (NHSLA) took over the full financial responsibility for all Existing Liabilities Scheme (ELS) cases unsettled at that date and from 1 April 2002 all Clinical Negligence Scheme for Trusts (CNST) cases. Provisions for these are included in the accounts of the NHSLA. Although the NHSLA is administratively responsible for all cases from 1 April 2000, the legal liability remains with the PCTs.

The NHSLA operates a risk pooling scheme under which the PCT pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure in the year that it is due. The total value of clinical negligence provisions carried by the NHSLA on behalf of the PCT is disclosed at Note 32.

1.17 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, except for bonuses earned but not yet taken which, on the grounds of immateriality.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the PCT commits itself to the retirement, regardless of the method of payment.

1.18 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.19 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.20 Grant making

Under section 256 of the National Health Service Act 2006, the PCT has the power to make grants to local authorities, voluntary bodies and registered social landlords to finance capital or revenue schemes. A liability in respect of these grants is recognised when the PCT has a present legal or constructive obligation which occurs when all of the conditions attached to the payment have been met.

1.21 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the PCT, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1. Accounting policies (continued)

1.22 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The PCT as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the PCT's net operating cost.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The PCT as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the PCT's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the PCT's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.23 Foreign exchange

Transactions which are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of each transaction, except where rates do not fluctuate significantly, in which case an average rate for a period is used. Resulting exchange gains and losses are taken to the Statement of Comprehensive Net Expenditure.

1.24 Provisions

Provisions are recognised when the PCT has a present legal or constructive obligation as a result of a past event, it is probable that the PCT will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates of: short term minus 1.8%, medium term minus 1% and long term plus 2.2% in real terms. For post employment benefit provisions the rate is 2.35% in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the PCT has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the PCT has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1. Accounting policies (continued)

1.25 Financial Instruments

Financial assets

Financial assets are recognised when the PCT becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets 'at fair value through profit and loss'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Statement of Comprehensive Net Expenditure. The net gain or loss incorporates any interest earned on the financial asset. [Disclose how fair value is determined]

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the Statement of Comprehensive Net Expenditure on de-recognition. Fair value is determined by the

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the Statement of Financial Position date, the PCT assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Net Expenditure and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Net Expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1. Accounting policies (continued)

Financial liabilities
Financial liabilities are recognised on the Statement of Financial Position when the PCT becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or other financial liabilities.

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Statement of Comprehensive Net Expenditure. The net gain or loss incorporates any interest earned on the financial asset.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest

1.26 Private Finance Initiative (PFI) and NHS LIFT transactions

HM Treasury has determined that government bodies shall account for infrastructure LIFT schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The PCT therefore recognises the LIFT asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

a) Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

b) LIFT assets, liabilities, and finance costs

LIFT assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the PCT's approach for each relevant class of asset in accordance with the principles of IAS 16."

A LIFT liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

1. Accounting policies (continued)

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

c) Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the PCT's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the PCT to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the PCT's Statement of Comprehensive Net Expenditure.

Other assets contributed by the PCT to the operator

Assets contributed (e.g. cash payments, surplus property) by the PCT to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the PCT, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1. Accounting policies (continued)

1.27 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2012-13. The application of the Standards as revised would not have a material impact on the accounts for 2012-13, were they applied in that year:

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation

2 Operating segments

Lambeth PCT has operated as one segment since the transfer of community health services to Guy's and St Thomas' NHS Foundation Trust on 1st April 2011.

3. Financial Performance Targets

3.1 Revenue Resource Limit

	2012-13 £000	2011-12 £000
The PCTs' performance for the year ended 2012-13 is as follows:		
Total Net Operating Cost for the Financial Year	**705,176**	680,450
Net operating cost plus (gain)/loss on transfers by absorption		
Adjusted for prior period adjustments in respect of errors	**0**	0
Revenue Resource Limit	**712,269**	687,317
Under/(Over)spend Against Revenue Resource Limit (RRL)	7,093	6,867

3.2 Capital Resource Limit

	2012-13 £000	2011-12 £000
The PCT is required to keep within its Capital Resource Limit.		
Capital Resource Limit	**24,955**	1,669
Charge to Capital Resource Limit	**24,650**	1,657
(Over)/Underspend Against CRL	**305**	**12**

Charge to CRL is additions of £24,691k (note 12.1) less net book value of assets disposed of £41k (note 24) equals £24,650k. This includes the inception of LIFT asset Akerman Road building of £19,382K.

3.3 Provider full cost recovery duty

	2012-13 £000	2011-12 £000
The PCT is required to recover full costs in relation to its provider functions.		
Provider gross operating costs	**0**	0
Provider Operating Revenue	**0**	0
Net Provider Operating Costs	**0**	0
Costs Met Within PCTs Own Allocation	**0**	0
Under/(Over) Recovery of Costs	**0**	0

From the 1st April 2011, the provider function was transferred to Guy's and St Thomas' NHS Foundation Trust.

3.4 Under/(Over)spend against cash limit

	2012-13 £000	2011-12 £000
Total Charge to Cash Limit	**696,624**	677,810
Cash Limit	**705,625**	677,810
Under/(Over)spend Against Cash Limit	**9,001**	**0**

The PCT declared a surplus cash of £9.001K which was not reduced from the cash limit.

3.5 Reconciliation of Cash Drawings to Parliamentary Funding (current year)

	2012-13 £000
Total cash received from DH (Gross)	639,580
Sub total: net advances	**639,580**
Plus: cost of Dentistry Schemes (central charge to cash limits)	14,247
Plus: drugs reimbursement (central charge to cash limits)	42,797
Parliamentary funding credited to General Fund	**696,624**

4 Miscellaneous Revenue

	2012-13 Total	2012-13 Admin	2012-13 Programme	2011-12
	£000	£000	£000	£000
Fees and Charges	**12**	12	0	12
Dental Charge income from Contractor-Led GDS & PDS	**2,661**		2,661	2,416
Dental Charge income from Trust-Led GDS & PDS	**0**		0	0
Prescription Charge income	**2,062**		2,062	1,966
Strategic Health Authorities	**2,387**	216	2,171	497
NHS Trusts	**607**	607	0	323
NHS Foundation Trusts	**6,294**	1,368	4,926	5,609
Primary Care Trusts Contributions to DATs	**0**		0	0
Primary Care Trusts - Other	**12,004**	7,130	4,874	4,631
Primary Care Trusts - Lead Commissioning	**0**	0	0	66
English RAB Special Health Authorities	**0**	0	0	0
NDPBs and Others (CGA)	**116**	116	0	0
Department of Health - SMPTB	**0**	0	0	0
Department of Health - Other	**142**	142	0	0
Recoveries in respect of employee benefits	**13,550**	13,550	0	13,692
Local Authorities	**1,787**	64	1,723	952
Patient Transport Services	**0**		0	0
Education, Training and Research	**2,192**	130	2,062	1,972
Non-NHS: Private Patients	**0**		0	0
Non-NHS: Overseas Patients (Non-Reciprocal)	**0**		0	0
NHS Injury Costs Recovery	**0**		0	0
Other Non-NHS Patient Care Services	**0**	0	0	0
Charitable and Other Contributions to Expenditure	**0**		0	10
Receipt of donated assets	**0**		0	0
Receipt of Government granted assets	**0**		0	0
Rental revenue from finance leases	**0**	0	0	0
Rental revenue from operating leases	**4,248**	1,869	2,379	3,338
Other revenue	**1,461**	152	1,309	2,949
Total miscellaneous revenue	**49,523**	**25,356**	**24,167**	**38,433**

From 2011/12 Lambeth PCT has hosted the NHS SE London Cluster with recoveries in respect of employee benefits of £13.6M in 2012/13. PCT income has increased in part due to Dangerous people with severe personalities disorders (DSPD) income of £4.2m received in 2012/13 which was previously received via a revenue resource allocation in 2011/12. Local Authorities income increased to due funding for midwifery, Speech and language therapy (SALT) and Gracefield Gardens.

5. Operating Costs

5.1 Analysis of operating costs:

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 Total £000
Goods and Services from Other PCTs				
Healthcare	64,887		64,887	54,803
Non-Healthcare	1,743	1,002	741	1,048
Total	66,630	1,002	65,628	55,851
Goods and Services from Other NHS Bodies other than FTs				
Goods and services from NHS Trusts	52,841	507	52,334	53,627
Goods and services (other, excl Trusts, FT and PCT))	694	317	377	1,043
Total	53,535	824	52,711	54,670
Goods and Services from Foundation Trusts	400,929	146	400,783	394,201
Purchase of Healthcare from Non-NHS bodies	47,493		47,493	43,454
Social Care from Independent Providers	0		0	0
Expenditure on Drugs Action Teams	0		0	0
Non-GMS Services from GPs	0	0	0	0
Contractor Led GDS & PDS (excluding employee benefits)	16,626		16,626	17,128
Salaried Trust-Led PDS & PCT DS (excluding employee benefits)	540		540	0
Chair, Non-executive Directors & PEC remuneration	26	26	0	163
Executive committee members costs	169	169	0	171
Consultancy Services	4,572	4,269	303	603
Prescribing Costs	35,136		35,136	37,298
G/PMS, APMS and PCTMS (excluding employee benefits)	55,274	0	55,274	57,085
Pharmaceutical Services	0		0	0
Local Pharmaceutical Services Pilots	0		0	0
New Pharmacy Contract	9,285		9,285	10,009
General Ophthalmic Services	2,226		2,226	2,114
Supplies and Services - Clinical	945	0	945	1,618
Supplies and Services - General	1,070	52	1,018	1,023
Establishment	3,502	2,704	798	2,642
Transport	21	18	3	64
Premises	8,486	5,498	2,988	7,566
Impairments & Reversals of Property, plant and equipment	4,538	0	4,538	616
Impairments and Reversals of non-current assets held for sale	0	0	0	0
Depreciation	1,804	0	1,804	1,429
Amortisation	0	0	0	0
Impairment & Reversals Intangible non-current assets	0	0	0	0
Impairment and Reversals of Financial Assets	0	0	0	0
Impairment of Receivables	26	0	26	74
Inventory write offs	0	0	0	0
Research and Development Expenditure	0	0	0	0
Audit Fees	122	122	0	203
Other Auditors Remuneration	1	1	0	0
Clinical Negligence Costs	0	0	0	0
Education and Training	639	570	69	441
Grants for capital purposes	638	0	638	0
Grants for revenue purposes	0	0	0	0
Impairments and reversals for investment properties	0	0	0	0
Other	11,280	10,409	871	7,480
Total Operating costs charged to Statement of Comprehensive Net Expenditure	725,513	25,810	699,703	695,903

Operating Costs for commissioned services has increased due to the purchasing of increased activity during 2012/13 as well as expenditure for joint health and social care funding and £2M for winter pressures. Consultancy costs mainly increased due to transition costs for South East London Cluster and staffing costs for Lambeth PCTs HIV/AIDs prevention project. Other costs relate to Teenage Pregnancy Grants £567k, Office of London projects (Nice Technology and others £485k), London Procurement Programme £600k and Medical Claims £207k. £2.3m relates to non practice specific payments for health checks, drugs misuse and other enhanced services. £3.38m relates to cost for South East London Cluster transition.

Employee Benefits (excluding capitalised costs)				
Employee Benefits associated with PCTMS	0	0	0	0
Trust led PDS and PCT DS	0	0	0	0
PCT Officer Board Members	467	467	0	1,533
Other Employee Benefits	26,697	22,706	3,991	20,055
Total Employee Benefits charged to SOCNE	27,164	23,173	3,991	21,588
Total Operating Costs	752,677	48,983	703,694	717,491

PCT Officer Board Member costs include the members of the NHS SE London Board . These costs are shown gross and recharged to the other Cluster PCTs under miscellaneous revenue.

Analysis of grants reported in total operating costs				
For capital purposes				
Grants to fund Capital Projects - GMS	0	0	0	0
Grants to Local Authorities to Fund Capital Projects	0	0	0	0
Grants to Private Sector to Fund Capital Projects	638	0	638	0
Grants to Fund Capital Projects - Dental	0	0	0	0
Grants to Fund Capital Projects - Other	0	0	0	0
Total Capital Grants	638	0	638	0
Grants to fund revenue expenditure				
To Local Authorities	0	0	0	0
To Private Sector	0	0	0	0
To Other	0	0	0	0
Total Revenue Grants	0	0	0	0
Total Grants	638	0	638	0

	Total	Commissioning Services	Public Health
PCT Running Costs 2012-13			
Running costs (£000s)	10,559	9,166	1,393
Weighted population (number in units)*	351,815	351,815	351,815
Running costs per head of population (£ per head)	30	26	4
PCT Running Costs 2011-12			
Running costs (£000s)	11,930	10,307	1,623
Weighted population (number in units)	351,815	351,815	351,815
Running costs per head of population (£ per head)	34	29	5

* Weighted population figures are not available for 2012-13 as the weighted capitation formula for PCT allocations was not updated for 2012-13. This was because it was decided to give all PCTs the same percentage growth in their allocations in this transitional year rather than differential growth based on a weighted capitation formula

Therefore, 2011-12 weighted populations have been used when calculated the Running Costs per head of population in 2012-13

5.2 Analysis of operating expenditure by expenditure classification	2012-13 £000	2011-12 £000
Purchase of Primary Health Care		
GMS / PMS/ APMS / PCTMS	56,616	58,816
Prescribing costs	35,097	37,933
Contractor led GDS & PDS	13,651	16,817
Trust led GDS & PDS	540	469
General Ophthalmic Services	2,226	2,114
Department of Health Initiative Funding	0	0
Pharmaceutical services	0	0
Local Pharmaceutical Services Pilots	0	0
New Pharmacy Contract	7,254	10,051
Non-GMS Services from GPs	0	0
Other	0	0
Total Primary Healthcare purchased	**115,384**	126,200
Purchase of Secondary Healthcare		
Learning Difficulties	5,291	5,993
Mental Illness	101,559	106,628
Maternity	24,149	25,277
General and Acute	323,993	313,594
Accident and emergency	14,958	14,333
Community Health Services	69,279	67,444
Other Contractual	18,962	11,671
Total Secondary Healthcare Purchased	**558,191**	544,940
Grant Funding		
Grants for capital purposes	638	0
Grants for revenue purposes	0	0
Total Healthcare Purchased by PCT	**674,213**	**671,140**
PCT self-provided secondary healthcare included above	0	0
Social Care from Independent Providers	0	0
Healthcare from NHS FTs included above	400,929	392,298

6. Operating Leases

6.1 PCT as lessee

	Land £000	Buildings £000	Other £000	2012-13 Total £000	2011-12 £000
Payments recognised as an expense					
Minimum lease payments				**2,322**	2,356
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**2,322**	**2,356**
Payable:					
No later than one year	**0**	**1,524**	**26**	**1,550**	1,145
Between one and five years	**0**	**1,695**	**104**	**1,799**	1,898
After five years	**0**	**3,121**	**0**	**3,121**	3,449
Total	**0**	**6,340**	**130**	**6,470**	**6,492**

Total future sublease payments expected to be received	0	0

6.2 PCT as lessor

Lambeth PCT has entered into short term leases with Guys and St Thomas's Foundation Trust for the properties providing community services which transferred under TCS on 1st April 2011. There is nothing shown as receivable later than one year for these community services properties as these will be transferred to NHS Property Services Ltd and Guys and St Thomas FT from April 2013 as part of the Lambeth PCT transfer scheme.

Lambeth PCT has a lease with BBH - LSL LiftCo to occupy Gracefield Gardens, Baldry Gardens and Akerman Road for a 25 year period expiring 2032, 2035 and 2037 respectively. Part of the building has been sub leased by the PCT to other healthcare service providers e.g. Guys and St Thomas' and GPs.

	2012-13 £000	2011-12 £000
Recognised as income		
Rental Revenue	**4,248**	3,338
Contingent rents	**0**	0
Total	**4248**	3,338
Receivable:		* Restated
No later than one year	**1,219**	1,074
Between one and five years	**4,015**	3,753
After five years	**7,876**	8,773
Total	**13,110**	13,600

7. Employee benefits and staff numbers

7.1 Employee benefits

	2012-13			Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Gross Expenditure									
Salaries and wages	22,972	19,282	3,690	14,767	13,495	1,272	8,205	5,787	2,418
Social security costs	1,679	1,551	128	1,679	1,551	128	0	0	0
Employer Contributions to NHS BSA - Pensions Division	2,223	2,050	173	2,223	2,050	173	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	290	290	0	290	290	0	0	0	0
Total employee benefits	27,164	23,173	3,991	18,959	17,386	1,573	8,205	5,787	2,418
Less recoveries in respect of employee benefits (table below)	(13,550)	(13,550)	0	(13,550)	(13,550)	0	0	0	0
Total - Net Employee Benefits including capitalised costs	13,614	9,623	3,991	5,409	3,836	1,573	8,205	5,787	2,418
Employee costs capitalised	0	0	0	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	27,164	23,173	3,991	18,959	17,386	1,573	8,205	5,787	2,418
Recognised as:									
Commissioning employee benefits	27,164			18,959			8,205		
Provider employee benefits	0			0			0		
Gross Employee Benefits excluding capitalised costs	27,164			18,959			8,205		

	2012-13			Permanently employed			Other		
	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000	Admin £000	Programme £000
Employee Benefits - Revenue									
Salaries and wages	11,298	11,298	0	11,298	11,298	0	0	0	0
Social Security costs	976	976	0	976	976	0	0	0	0
Employer Contributions to NHS BSA - Pensions Division	1,276	1,276	0	1,276	1,276	0	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other Post Employment Benefits	0	0	0	0	0	0	0	0	0
Other Employment Benefits	0	0	0	0	0	0	0	0	0
Termination Benefits	0	0	0	0	0	0	0	0	0
TOTAL excluding capitalised costs	13,550	13,550	0	13,550	13,550	0	0	0	0

Employee Benefits - Prior- year

	Total £000	Permanently employed £000	Other £000
Employee Benefits Gross Expenditure 2011-12			
Salaries and wages	18,136	14,904	3,232
Social security costs	1,491	1,491	0
Employer Contributions to NHS BSA - Pensions Division	1,961	1,961	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total gross employee benefits	21,588	18,356	3,232
Less recoveries in respect of employee benefits	(13,692)	(13,692)	0
Total - Net Employee Benefits including capitalised costs	7,896	4,664	3,232
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	21,588	18,356	3,232
Recognised as:			
Commissioning employee benefits	21,588		
Provider employee benefits	0		
Gross Employee Benefits excluding capitalised costs	21,588		

Cluster staff costs of £13,550,000 were recharged to the other five PCTs in the NHS SE London.

7.2 Staff Numbers

	2012-13			2011-12		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Average Staff Numbers						
Medical and dental	5	5	0	6	6	0
Ambulance staff	0	0	0	0	0	0
Administration and estates	317	212	105	263	215	48
Healthcare assistants and other support staff	0	0	0	1	1	0
Nursing, midwifery and health visiting staff	3	3	0	2	2	0
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	4	4	0	4	4	0
Social Care Staff	0	0	0	0	0	0
Other	47	47	0	54	54	0
TOTAL	376	271	105	328	280	48
Of the above - staff engaged on capital projects	0	0	0	8	8	0

Cluster staff whole time equivalents (wtes) are reported in Lambeth PCT as host for NHS SE London.

7.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	1,177	2,411
Total Staff Years	287	446
Average working Days Lost	4.10	5.40

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	0	3
	£000s	£000s
Total additional pensions liabilities accrued in the year	0	120

7.4 Exit Packages agreed during 2012-13

	2012-13			2011-12		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Lees than £10,000	**0**	**0**	**0**	0	0	**0**
£10,001-£25,000	**0**	**0**	**0**	0	0	**0**
£25,001-£50,000	**1**	**0**	**1**	0	0	**0**
£50,001-£100,000	**0**	**0**	**0**	0	1	**1**
£100,001 - £150,000	**0**	**0**	**0**	0	0	**0**
£150,001 - £200,000	**0**	**0**	**0**	0	0	**0**
>£200,000	**1**	**0**	**1**	0	0	**0**
Total number of exit packages by type (total cost	**2**	**0**	**2**	**0**	**1**	**1**
	£s	**£s**	**£s**	**£s**	**£s**	**£s**
Total resource cost	289,480	0	**289,480**	0	100,000	**100,000**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme or MARS. Where the PCT has agreed early retirements, the additional costs are met by the PCT and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

7.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the PCT commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

8. Better Payment Practice Code

8.1 Measure of compliance

	2012-13 Number	2012-13 £000	2011-12 Number	2011-12 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**15,095**	**84,822**	11,175	63,713
Total Non-NHS Trade Invoices Paid Within Target	**13,922**	**79,672**	10,364	60,058
Percentage of NHS Trade Invoices Paid Within Target	92.23%	93.93%	92.74%	94.26%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,631**	**578,428**	4,436	529,520
Total NHS Trade Invoices Paid Within Target	**4,392**	**556,123**	4,142	503,556
Percentage of NHS Trade Invoices Paid Within Target	94.84%	96.14%	93.37%	95.10%

The Better Payment Practice Code requires the PCT to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

8.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2012-13 £000	2011-12 £000
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

9. Investment Income

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Rental Income				
PFI finance lease revenue (planned)	0	0	0	0
PFI finance lease revenue (contingent)	0	0	0	0
Other finance lease revenue	0	0	0	0
Subtotal	0	0	0	0
Interest Income				
LIFT: equity dividends receivable	0	0	0	0
LIFT: loan interest receivable	127	0	127	9
Bank interest	0	0	0	0
Other loans and receivables	0	0	0	0
Impaired financial assets	0	0	0	0
Other financial assets	0	0	0	0
Subtotal	127	0	127	9
Total investment income	127	0	127	9

10. Other Gains and Losses

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Gain/(Loss) on disposal of assets other than by sale (PPE)	0	0	0	19
Total	0	0	0	19

11. Finance Costs

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000	2011-12 £000
Interest on obligations under LIFT contracts:				
- main finance cost	2,149	0	2,149	1,370
- contingent finance cost	0	0	0	0
Interest on late payment of commercial debt	0	0	0	0
Other interest expense	0	0	0	0
Total interest expense	2,149	0	2,149	1,370
Other finance costs	0	0	0	0
Provisions - unwinding of discount	0		0	50
Total	2,149	0	2,149	1,420

12.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2012	**15,650**	**30,316**	**0**	**0**	**932**	**0**	**4,163**	**2,463**	**53,524**
Opening Balance restatement adjustment	**5,350**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5,350**
Restated Opening Cost or valuation:	**21,000**	**30,316**	**0**	**0**	**932**	**0**	**4,163**	**2,463**	**58,874**
Additions of Assets Under Construction				0					**0**
Additions Purchased	1,047	19,727	0		132	0	3,304	481	**24,691**
Additions Donated	0	0	0	0	0	0	0	0	**0**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0		0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(69)	0	0	0	**(69)**
Upward revaluation/positive indexation	275	263	0	0	0	0	0	0	**538**
Impairments/negative indexation	0	(1,245)	0	0	0	0	0	0	**(1,245)**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	(47)	(5,355)	0	0	0	0	0	0	**(5,402)**
At 31 March 2013	**22,275**	**43,706**	**0**	**0**	**995**	**0**	**7,467**	**2,944**	**77,387**
Depreciation									
At 1 April 2012	**0**	**0**	**0**	**0**	**606**	**0**	**2,258**	**1,538**	**4,402**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		(28)	0	0	0	**(28)**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	47	4,491	0	0	0	0	0	0	**4,538**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	864	0		170	0	610	160	**1,804**
Transfers (to)/from Other Public Sector Bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	(47)	(5,355)	0	0	0	0	0	0	**(5,402)**
At 31 March 2013	**0**	**0**	**0**	**0**	**748**	**0**	**2,868**	**1,698**	**5,314**
Net Book Value at 31 March 2013	**22,275**	**43,706**	**0**	**0**	**247**	**0**	**4,599**	**1,246**	**72,073**
Purchased	22,275	39,909	0	0	247	0	4,599	1,246	**68,276**
Donated	0	3,797	0	0	0	0	0	0	**3,797**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**22,275**	**43,706**	**0**	**0**	**247**	**0**	**4,599**	**1,246**	**72,073**
Asset financing:									
Owned	14,150	12,516	0	0	247	0	4,232	935	**32,080**
Held on finance lease	5,350	5,070	0	0	0	0	0	0	**10,420**
On-SOFP LIFT contracts	2,775	26,120	0	0	0	0	367	311	**29,573**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**22,275**	**43,706**	**0**	**0**	**247**	**0**	**4,599**	**1,246**	**72,073**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	**7,755**	**3,461**	**0**	**0**	**0**	**0**	**0**	**52**	**11,268**
Movements (specify)	275	(982)	0	0	0	0	0	0	**(707)**
At 31 March 2013	**8,030**	**2,479**	**0**	**0**	**0**	**0**	**0**	**52**	**10,561**

The movement in the revaluation reserve represents impairments (£1,213k) and positive indexation of £637k.

Additions to Assets Under Construction in 2012-13

	£000
Land	0
Buildings excl Dwellings	0
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**0**

12.2 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 1 April 2011	**16,300**	**31,954**	**0**	**0**	**889**	**0**	**2,884**	**2,382**	**54,409**
Additions - purchased	0	461	0	0	43	0	1,279	81	**1,864**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	0	0	0	**0**
Impairments	(425)	(968)	0	0	0	0	0	0	**(1,393)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	(225)	(1,131)	0	0	0	0	0	0	**(1,356)**
At 31 March 2012	**15,650**	**30,316**	**0**	**0**	**932**	**0**	**4,163**	**2,463**	**53,524**
Depreciation									
At 1 April 2011	**0**	**0**	**0**		**425**	**0**	**1,896**	**1,392**	**3,713**
Reclassifications		0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	225	363	0	0	16	0	0	12	**616**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	768	0		165	0	362	134	**1,429**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Cumulative dep netted off cost following revaluatio	(225)	(1,131)	0	0	0	0	0	0	**(1,356)**
At 31 March 2012	**0**	**0**	**0**	**0**	**606**	**0**	**2,258**	**1,538**	**4,402**
Net Book Value at 31 March 2012	**15,650**	**30,316**	**0**	**0**	**326**	**0**	**1,905**	**925**	**49,122**
Purchased	15,650	26,399	0	0	326	0	1,905	925	**45,205**
Donated	0	3,917	0	0	0	0	0	0	**3,917**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**15,650**	**30,316**	**0**	**0**	**326**	**0**	**1,905**	**925**	**49,122**
Asset financing:									
Owned	13,875	18,028	0	0	326	0	1,905	925	**35,059**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	1,775	12,288	0	0	0	0	0	0	**14,063**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**15,650**	**30,316**	**0**	**0**	**326**	**0**	**1,905**	**925**	**49,122**

12.3 Property, plant and equipment

Land and Buildings were revalued by the independent District Valuer with an effective date of 31st March 2013.

Economic Lives of Non-Current Assets	Min life Years	Max life Years
Property, Plant and Equipment		
Buildings exc Dwellings	5	70
Dwellings	0	0
Plant & Machinery	5	5
Transport Equipment	7	7
Information Technology	5	5
Furniture and Fittings	10	10

13.1 Intangible non-current assets

The PCT held the NIL intangible non-current assets 2012/13 ; 2011/12 Nil.

14. Analysis of impairments and reversals recognised in 2012-13

	2012-13 Total £000	2012-13 Admin £000	2012-13 Programme £000
Property, Plant and Equipment impairments and reversals taken to SoCNE			
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**
Unforeseen obsolescence	0		0
Loss as a result of catastrophe	0		0
Other	3,910		3,910
Changes in market price	628		628
Total charged to Annually Managed Expenditure	**4,538**		**4,538**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve			
Changes in market price	1,245		
Total impairments for PPE charged to reserves	**1,245**		
Total Impairments of Property, Plant and Equipment	**5,783**	**0**	**4,538**
Total Impairments charged to Revaluation Reserve	1,245		
Total Impairments charged to SoCNE - DEL	0	0	0
Total Impairments charged to SoCNE - AME	4,538		4,538
Overall Total Impairments	**5,783**	**0**	**4,538**
Of which:			
Impairment on revaluation to "modern equivalent asset" basis	**0**	0	0

As a result of the District Valuer's valuation on 31 March 2013 the carrying values of land and buildings were revised.

15 Investment property

The PCT has no investment property in 2012/13 (2011/12 Nil).

16 Commitments

16.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	**0**	750
Intangible assets	**0**	0
Total	**0**	750

16.2 Other financial commitments

The trust has not entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements)

17 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with other Central Government Bodies	2,147	0	2,446	0
Balances with Local Authorities	428	0	24	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,522	0	8,358	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	3,996	0	29,575	0
At 31 March 2013	**8,093**	**0**	**40,403**	**0**
prior period:				
Balances with other Central Government Bodies	4,567	0	1,019	0
Balances with Local Authorities	810	0	0	0
Balances with NHS Trusts and Foundation Trusts	4,625	0	9,789	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,353	0	28,670	0
At 31 March 2012	**11,355**	**0**	**39,478**	**0**

18 Inventories

The PCT held no inventories as at 31st March 2013. (2011/12 £nil)

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables - revenue	**2,672**	9,173	**0**	0
NHS receivables - capital	**312**	0	**0**	0
NHS prepayments and accrued income	**663**	19	**0**	0
Non-NHS receivables - revenue	**1,797**	1,484	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**1,647**	649	**0**	0
Provision for the impairment of receivables	**(268)**	(316)	**0**	0
VAT	**1,158**	219	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**112**	127	**0**	0
Total	**8,093**	11,355	**0**	0
Total current and non current	**8,093**	11,355		

The great majority of trade is with other NHS bodies, including other Primary Care Trusts as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

19.2 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By up to three months	**2,358**	3,527
By three to six months	**0**	20
By more than six months	**300**	223
Total	**2,658**	3,770

19.3 Provision for impairment of receivables

	2012-13 £000	**2011-12 £000**
Balance at 1 April 2012	**(316)**	(253)
Amount written off during the year	**74**	11
Amount recovered during the year	**15**	318
(Increase)/decrease in receivables impaired	**(41)**	(392)
Balance at 31 March 2013	**(268)**	(316)

Lambeth PCT accounting policy is to provide for all non NHS debtors older than one year with specific adjustments made for known debts that may or may not be doubtful. The NHS debtors are part of agreement of NHS balances exercise. No bad debt provision is made for NHS debtors. In line with NHS London's guidance to reduce outstanding debtors to less than 90 days, the PCT has made a provision for 2012/13 for all Non NHS debtors older than 90 days.

20 NHS LIFT investments

	Loan £000	Share capital £000	Total £000
Balance at 1 April 2012	**716**	**3**	**719**
Additions	**0**	**0**	**0**
Disposals	**0**	**0**	**0**
Loan repayments	**0**	**0**	**0**
Revaluations	**0**	**0**	**0**
Loans repayable within 12 months	**0**	**0**	**0**
Balance at 31 March 2013	**716**	**3**	**719**
Balance at 1 April 2011	724	3	727
Additions	0	0	0
Disposals	0	0	0
Loan repayments	(8)	0	(8)
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2012	**716**	**3**	**719**

21.2 Other Financial Assets - Non Current

	31 March 2013 £000	31 March 2012 £000
Opening balance 1 April	**719**	0
Additions	**0**	0
Revaluation	**0**	0
Impairments	**0**	0
Impairment Reversals	**0**	0
Transferred to current financial assets	**0**	0
Disposals	**0**	0
Transfers (to)/from Other Public Sector Bodies in year	**0**	0
Total Other Financial Assets - Non Current	**719**	0

21.3 Other Financial Assets - Capital Analysis

	31 March 2013 £000	31 March 2012 £000
Capital Expenditure	**0**	0
Capital Income	**0**	0

22 Other current assets

	31 March 2013 £000	31 March 2012 £000
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

23 Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Opening balance	**19**	0
Net change in year	**7**	19
Closing balance	**26**	19
Made up of		
Cash with Government Banking Service	**26**	19
Commercial banks	**0**	0
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**26**	19
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**26**	19
Patients' money held by the PCT, not included above	**0**	0

24 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2012	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
										0
Balance at 1 April 2011	70	137	0	0	0	0	0	0	0	**207**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	(70)	(137)	0	0	0	0	0	0	0	**(207)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	**0**

Revaluation reserve balances in respect of non-current assets held for sale were:

At 31 March 2012	0
At 31 March 2013	0

25 Trade and other payables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Interest payable	**0**	0		
NHS payables - revenue	**8,676**	9,773	**0**	0
NHS payables - capital	**0**	353	**0**	0
NHS accruals and deferred income	**1,831**	669	**0**	0
Family Health Services (FHS) payables	**12,271**	9,289		
Non-NHS payables - revenue	**10,134**	6,648	**0**	0
Non-NHS payables - capital	**11**	74	**0**	0
Non_NHS accruals and deferred income	**6,766**	11,651	**0**	0
Social security costs	**26**	0		
VAT	**0**	0	**0**	0
Tax	**244**	13		
Payments received on account	**0**	1	**0**	0
Other	444	1,007	0	0
Total	**40,403**	39,478	**0**	0
Total payables (current and non-current)	**40,403**	**39,478**		

26 Other liabilities

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
PFI/LIFT deferred credit	**0**	0	**0**	**0**
Lease incentives	**0**	0	**0**	**0**
Other *[specify]*	**0**	0	**0**	**0**
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

27 Borrowings

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**356**	53	**35,588**	17,037
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**356**	**53**	**35,588**	**17,037**
Total other liabilities (current and non-current)	**35,944**	**17,090**		

Borrowings/Loans - Payment of Principal Falling Due in:

	DH	Other	Total
	£000s	**£000s**	**£000s**
0 - 1 Years	356	0	**356**
1 - 2 Years	0	0	**0**
2 - 5 Years	0	0	**0**
Over 5 Years	35,588	0	**35,588**
TOTAL	**35,944**	**0**	**35,944**

The LIFT liability increased this financial year as a result of the inception of Akerman Road whose liability at 31 March 2013 is £18.908m.

28 Other financial liabilities

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Embedded Derivatives at Fair Value through SoCNE	**0**	0	**0**	0
Financial liabilities carried at fair value through SoCNE	**0**	0	**0**	0
Amortised Cost	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

29 Deferred income

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Opening balance at1 April 2012	**0**	0	**0**	0
Deferred income addition	**0**	0	**0**	0
Transfer of deferred income	**0**	0	**0**	0
Current deferred Income at 31 March 2013	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

30 Finance lease obligations

The PCT has no finance lease obligations in 2012/13 (2011/12 Nil). On SoFP Lift schemes are shown under Borrowing (Note 27).

31 Finance lease receivables as lessor

Amounts receivable under finance leases (buildings)	Gross investments in leases		Present value of minimum lease	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**-**	-
Present value of minimum lease payments	**0**	0	**0**	0
Less allowance for uncollectible lease payments:	**0**	0	**0**	0
Total finance lease receivable recognised in the statement of financial position	**0**	**0**	**0**	**0**
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**0**	0
			0	0

Amounts receivable under finance leases (land)	Gross investments in leases		Present value of minimum lease	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**-**	-
Present value of minimum lease payments	**0**	0	**0**	0
Less allowance for uncollectible lease payments:	**0**	**0**	**0**	0
Total finance lease receivable recognised in the statement of financial position	**0**	**0**	**0**	**0**
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**0**	0
			0	0

Amounts receivable under finance leases (other)	Gross investments in leases		Present value of minimum lease	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0	**-**	-
Present value of minimum lease payments	**0**	0	**0**	0
Less allowance for uncollectible lease payments:	**0**	**0**	**0**	0
Total finance lease receivable recognised in the statement of financial position	**0**	**0**	**0**	**0**
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**0**	0
			0	0

Finance Leases (as a Lessor)	**31 March 2013 £000**	31 March 2012 £000
The unguaranteed residual value accruing to the PCT is	**0**	**0**
Accumulated allowance for uncollectible minimum lease payments receivable	**0**	**0**

Rental Income	**31 March 2013 £000**	31 March 2012 £000
Contingent rent	**0**	0
Other	**0**	0
Total rental income	**0**	0

32 Provisions

Comprising:

	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	**1,556**	0	21	521	292	625	97
Arising During the Year	**4,189**	0	0	0	3,593	387	209
Utilised During the Year	**(16)**	0	0	(9)	(7)	0	0
Reversed Unused	**(347)**	0	(21)	(229)	0	0	(97)
Unwinding of Discount	**0**	0	0	0	0	0	0
Change in Discount Rate	**0**	0	0	0	0	0	0
Transferred (to)/from otherPublic Sector bodies	**0**	0	0	0	0	0	0
Balance at 31 March 2013	**5,382**	**0**	**0**	**283**	**3,878**	**1,012**	**209**
Expected Timing of Cash Flows:							
No Later than One Year	**3,443**	**0**	**0**	**283**	**1,939**	**1,012**	**209**
Later than One Year and not later than Five Years	**1,939**	**0**	**0**	**0**	**1,939**	**0**	**0**
Later than Five Years	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2013	0
As at 31 March 2012	0

During 2012/13 the PCT increased its dilapidation provision for the lease on 1 Lower Marsh as well as for potential claims on Continuing Healthcare costs.

In March 2012 the Department of Health announced deadlines for individuals or their representatives to notify the relevant PCT if they believe there was a period of care between 1st April 2004 and 31st March 2012 where there is evidence that the individual should have been assessed for eligibility for NHS continuing healthcare (NHS CHC). This only applies to new cases ie where, the individual has not previously been assessed for NHS CHC during the identified period. The first deadline was the 30th September 2012 relating to claims between 1st April 2004 to 31st March 2011. The second deadline was 31st March 2013 relating to the period from 1st April 2011 to 31st March 2012. The PCT received a total of 77 claims representing a significant financial risk to the organisation. The process of assessing the impact of these claims has been ongoing through the year and a financial provision has been made based on estimates of the potential financial exposure using the latest information available at the time.

33 Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities		
Equal Pay	**0**	0
Other	**(4,721)**	(9)
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(4,721)**	(9)
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

This consists of the contingency liability for claims on Continuing Healthcare costs not provided above.

34 PFI and LIFT - additional information

The PCT has no PFI schemes.

The PCT three LIFT schemes (Gracefield Gardens, Baldry Gardens and 2012/13 inception of Akerman Road) neither is off-Statement of Financial Position - see below.

The LIFT scheme requires the operator, BBH LSL LiftCo, to provide the accommodation services related to the infrastructure assets on behalf of the public on behalf of the PCT. The PCT entered into the LIFT scheme to obtain accommodation and related services in order to fulfil its mandate of delivering health services to the public.

The arrangement requires the operator in return for Lease Plus payment to allow the use of the Infrastructure asset and provide facility management services.

At the conclusion of the lease the PCT has the option to enter into a new lease arrangement, vacate the premises or purchase the infrastructure assets at an adjusted market value.

Under IFRIC 12, the asset is treated as an asset of the trust; that the substance of the contract is that the trust has a finance lease and payments comprise two elements – imputed finance lease charges and service charges

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	**31 March 2013 £000**	31 March 2012 £000
Total Charge to Operating Expenses in year - OFF SOFP LIFT	**0**	0
Service element of on SOFP LIFT charged to operating expenses in year	**199**	190
Total	**199**	190

	31 March 2013 £000	31 March 2012 £000
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT		
LIFT Scheme Expiry Date:		
No Later than One Year	**208**	199
Later than One Year, No Later than Five Years	**1,397**	876
Later than Five Years	**13,848**	5,534
Total	**15,453**	6,609

The estimated annual payments in future years are expected to be materially different from those which the NHS Trust is committed to make during the next year. The likely financial effect of this is:

	31 March 2013 £000	31 March 2012 £000
Estimated capital value of project - off SOFP LIFT	0	0
Value of Deferred Assets - off SOFP LIFT	0	0
Value of Residual Interest - off SOFP LIFT	0	0

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	**31 March 2013 £000**	31 March 2012 £000
No Later than One Year	**3,074**	1,311
Later than One Year, No Later than Five Years	**11,401**	5,128
Later than Five Years	**77,129**	36,971
Subtotal	**91,604**	43,410
Less: Interest Element	**(55,660)**	(26,320)
Total	**35,944**	17,090

35 Impact of IFRS treatment - 2012-13

	Total £000	Admin £000	Programme £000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g LIFT/PFI)			
Depreciation charges	**374**	374	0
Interest Expense	**2,153**	2,153	0
Impairment charge - AME	**4,439**		4,439
Impairment charge - DEL	**0**	0	0
Other Expenditure	**0**	0	0
Revenue Receivable from subleasing	**0**	0	0
Total IFRS Expenditure (IFRIC12)	**6,966**	**2,527**	**4,439**
Revenue consequences of LIFT/PFI schemes under UK GAAP / ESA95 (net of any sublease income)	**(3,104)**	(3,104)	0
Net IFRS change (IFRIC12)	**3,862**	**(577)**	**4,439**

Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12	
Capital expenditure 2012-13	19,382
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0

36 Financial Instruments

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. As the cash requirements of the PCT are met through Parliamentary Funding, financial instruments play a more limited role in creating risk that would apply to a non-public sector body of a similar size. The majority of financial instruments relate to contracts for non-financial items in line with the PCT's expected purchase and usage requirements and the PCT is therefore exposed to little credit, liquidity or market list.

Currency risk

The PCT/Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The PCT/Trust has no overseas operations. The PCT/Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

PCTs are not permitted to borrow. The PCT therefore has low exposure to interest-rate fluctuations

Credit Risk

Because the majority of the PCT's income comes from funds voted by Parliament the PCT has low exposure to credit risk.

Liquidity Risk

The PCT is required to operate within limits set by the Secretary of State for the financial year and draws down funds from the Department of Health as the requirement arises. The PCT is not, therefore, exposed to significant liquidity risks.

36.1 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0			**0**
Receivables - NHS		2,984		**2,984**
Receivables - non-NHS		1,641		**1,641**
Cash at bank and in hand		26		**26**
Other financial assets	0	719	0	**719**
Total at 31 March 2013	**0**	**5,370**	**0**	**5,370**
Embedded derivatives	0			0
Receivables - NHS		9,173		9,173
Receivables - non-NHS		1,168		1,168
Cash at bank and in hand		19		19
Other financial assets	0	719	0	719
Total at 31 March 2012	0	11,079	0	11,079

36.2 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0		**0**
NHS payables		8,676	**8,676**
Non-NHS payables		33,005	**33,005**
Other borrowings		35,945	**35,945**
PFI & finance lease obligations		0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2013	**0**	**77,626**	**77,626**
Embedded derivatives	0		0
NHS payables		10,795	10,795
Non-NHS payables		28,669	28,669
Other borrowings		17,090	17,090
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	**0**	56,554	56,554

37 Related party transactions

Lambeth Primary Care Trust is a body corporate established by order of the Secretary of State for Health.

During the year the following Board Members and members of Clinical Commissioning Collaborative Committee and parties related to them have undertaken material transactions with Lambeth Primary Care Trust as follows:

	Services Received from Organisation	Payments to Related Party £
John Balazs - Binfield General Practice	Primary Care	1,003,300
John Balazs - Mawbey Brough Practice	Primary Care	1,204,182
Patricia Kirkman - Tulse Hill Practice	Primary Care	1,050,813
Adrian McLachlan - Heatherington Group Practice	Primary Care	1,574,002
Adrian McLachlan - Pavillion Medical Centre	Primary Care	712,494
Gillian Ellsbury - Paxton Green Group Practice	Primary Care	2,555,536
Redmond Walsh - Clapham Family Practice	Primary Care	2,670,132
Rajive Mitre - Lambeth Walk Group Practice	Primary Care	1,118,040

There were no material amounts due to or outstanding from the above related parties.

The Department of Health, as Lambeth PCT's parent department, is regarded as a related party. During the year 2012/13, Lambeth Primary Care Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below;

		Payments to Related Party £000
Guy's and St Thomas NHS Foundation Trust	Acute and Community healthcare	198,013
Kings Healthcare NHS Foundation Trust	Acute and Community healthcare	101,114
South London and Maudsley NHS Foundation Trust	Mental healthcare services	88,011
Croydon PCT	Specialist Services	56,708
St Georges Healthcare NHS Trust	Acute Healthcare Services	25,531
London Ambulance Services NHS Trust	Emergency Services	10,899
Southwark PCT	Commissioning of Healthcare	6,168
Lewisham PCT	Commissioning of Healthcare	1,785
London Borough of Lambeth	Learning disability, community healthcare	2,711

		Income from Related Party £000
Guy's and St Thomas NHS Foundation Trust	ICT and Site Service charges	8,430

2011/12	Services Received from Organisation	Payments to Related Party £
John Balazs - Binfield General Practice	Primary Care	1,057,375
Azhar Ala - Dr Ala's surgery	Primary Care	241,938
Patricia Kirkman - Tulse Hill Practice	Primary Care	1,148,879
Adrian McLachlan - Heatherington Group Practice	Primary Care	1,719,633
Gillian Ellsbury - Paxton Green Group Practice	Primary Care	2,598,697
Redmond Walsh - Clapham Family Practice	Primary Care	2,630,181
Rajive Mitre - Lambeth Walk Group Practice	Primary Care	1,124,709

		£000
Guy's and St Thomas NHS Foundation Trust	Acute and Community healthcare	193,746
Kings Healthcare NHS Foundation Trust	Acute and Community healthcare	93,757
South London and Maudsley NHS Foundation Trust	Mental healthcare services	91,700
St Georges Healthcare NHS Trust	Acute healthcare services	24,167
Southwark PCT	Commissioning of Healthcare	4,703
Lewisham PCT	Commissioning of Healthcare	1,324
London Borough of Lambeth	Learning disability, community healthcare	19,339

38 Losses and special payments

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	25,700	1
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
		0
Special payments in respect of he provision of family practitioner services	0	
9 a. Losses due to overpayments to practitioners of fees, allowances	44,046	1
Total losses	69,746	2
Total special payments	0	0
Total losses and special payments	69,746	2

The total number of losses cases in 2011-12 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses - PCT management costs	0	0
Special payments - PCT management costs	0	0
Losses in respect of the provision of family practitioner services	0	0
		0
Special payments in respect of he provision of family practitioner services	0	
Total losses	0	0
Total special payments	0	0
Total losses and special payments	0	0

Details of cases individually over £250,000	0	None

39 Third party assets

The PCT held no assets on behalf of other bodies and not accounted for in these Accounts

40 Pooled budget

The section 75 pooled fund agreement for Learning Disabilities was terminated with effect from 1 April 2012 to reflect the changes in arrangements resulting from the implementation of the Valuing People policy. There are from that date no pooled budgets

41 Cashflows relating to exceptional items

The PCT held no cashflow relating to exceptional items 2012/13 (NIL £'0 2011/12)

42.1 Events after the end of the reporting period

As disclosed within note 1 due to the Health and Social Care Bill as of 1st April 2013 the PCT in its current legal form will be abolished. As a result the PCT's functions will continue with either a Commissioning Support Unit (CSU), Clinical Commissioning Group (CCG), NHS England, NHS Foundation Trusts (FT) or Local Authorities (LA). Estates functions will be transferred to NHS Property Services Limited (NHS PS). Ultimate control will still reside with the Department of Health.

All assets and liabilites contained within the statement of financial position as at 31st March 2013 must be identified and agreed for transfer.

Under this NHS Transition, the PCT's assets and liabilities will be split between different 'Receivers' and, in some cases, multiple 'Receivers' will require access to an asset or be assigned a liability. The principles for the split of residual balances is still subject to Department of Health guidance.

The majority of assets and liabilities (including all land and buildings) will transfer by way of a 'Sender' organisation's Transfer Schemes. A Transfer Scheme is an instrument in writing made by the Secretary of State under sections 300 to 302 of the Act. It can deal with the transfers of staff, property and liabilities between those entities as specified in Schedules 22 and 23 to the Act but unlike Transfer Orders does not need to be laid before Parliament.

Where functions transfer, any claim, liability and financial asset, which relate to that will follow. However NHS England will take historical NHS Litigation Authority (NHSLA) indemnified clinical negligence claims, including those incurred but not reported relating to new functions of CCG's or Local Authorities.

The final year-end aggregate surplus generated by the PCTs in 2012/13 will be carried forward to NHS England in 2013/14. CCGs will not inherit legacy debt, but balances will transfer from PCTs, in line with provisions of the Act, based on the principles set out below subject to further guidance from the Department of health on the split of financial balances and related financial transactions.

- Liabilities that correspond to an asset which relate to a particular function should transfer with that asset from a sender to a receiver by reference to the destination of the function.

- Liabilities that correspond to a function or policy that is being moved from a sender should transfer to the nominated receiver for that function.

- Discrete, and current assets and liabilities, even if associated with a function continuing in 2013/14 will transfer to the Department of Health.

- Liabilities relating to the PCT as a statutory body in its own right that do not relate to an ongoing function such as VAT or tax liabilities, will transfer to the Department of Health.

- Employer liabilities will transfer to the new employer, where an individual's employment is transferred to a receiver organisation.

- Where employment of staff ceases prior to 1st April 2013, the employer liabilities related to those staff members will transfer to Department of Health.